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JOURNAL OF THE AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

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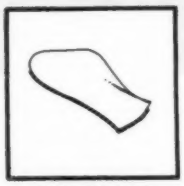

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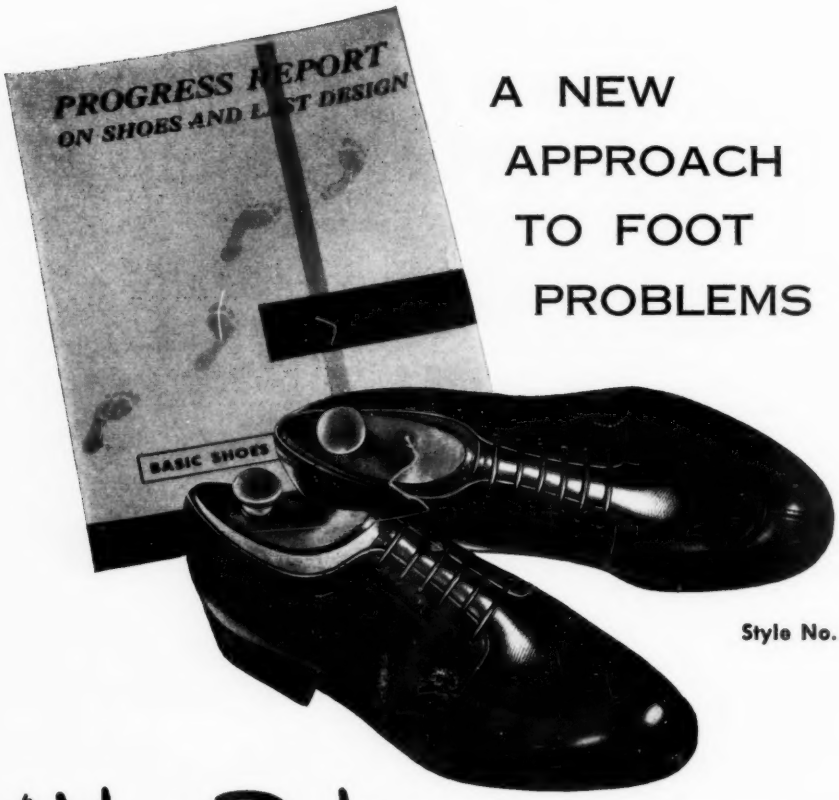

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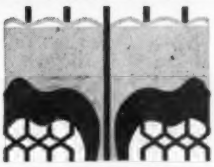

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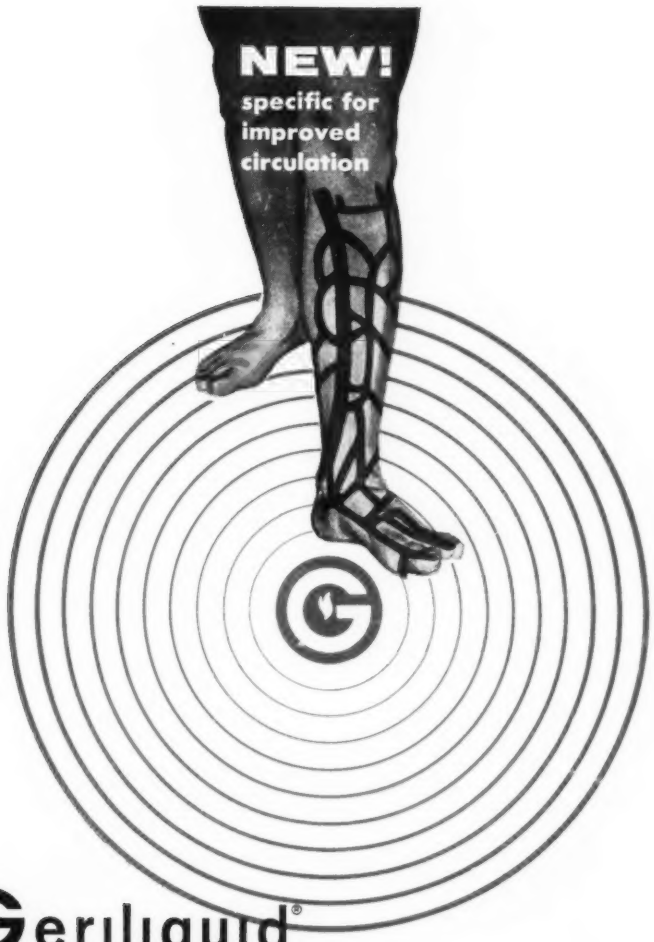

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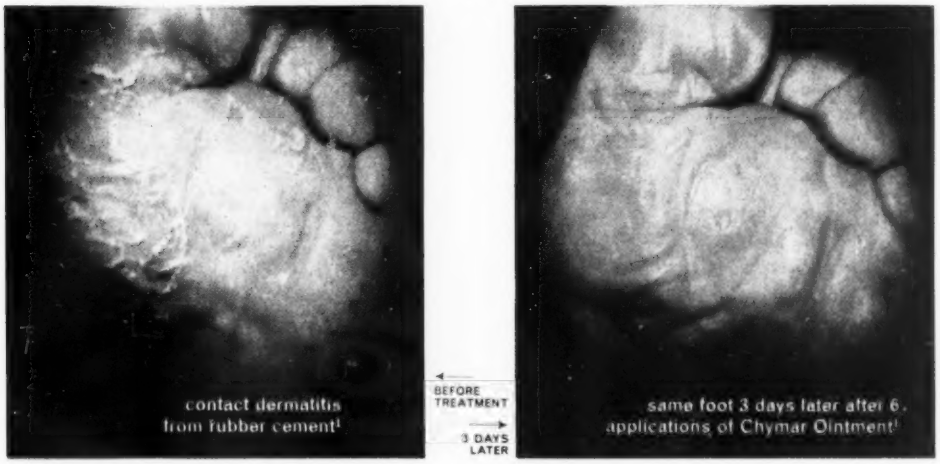

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1. Walker, M. H.: The Therapeutic Use of a Corticosteroid-Antibiotic-Enzyme Ointment in Common Foot Lesions, to be published. 2. Lucas, R. D.: Current Podiatry (March) 1960. 3. Streiker, F. B.: The Use of Chymotrypsin in Foot Orthopedics. Paper Presented at the Annual Meeting, American Podiatry Association, Chicago, Illinois, August, 1960.

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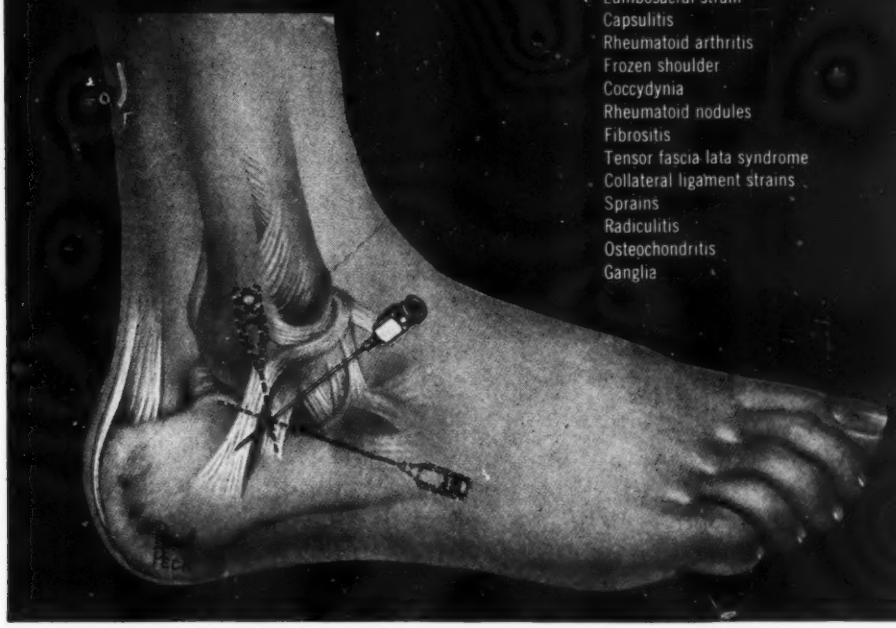

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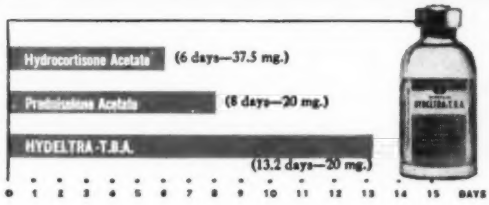
Hydrocortisone Acetate
(6 days—37.5 mg.)
Prednisolone Acetate
(5 days—20 mg.)
HYDELTRA-T.B.A.
(13.2 days—20 mg.)
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 DAYS

Dosage: the usual intra-articular, intra-bursal or soft tissue dose ranges from 20 to 30 mg. depending on location and extent of pathology.

Supplied: Suspension 'HYDELTRA'-T.B.A.—20 mg./cc. of prednisolone *tertiary*-butylacetate, in 5-cc. vials.

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The Alabama Medical Board of Examiners. **Board Secretary:**

Arizona

Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Julius Citron, 40 E. Thomas Rd., Phoenix, Ariz.

Arkansas

Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Bernard S. Paul, 1508 Rogers Ave., Fort Smith, Ark.

California

The California Chiropody Examination Committee will meet for examination tentatively March 7-8, and Aug. 22-23, 1961 in Los Angeles; June 20-21, 1961 in San Francisco; Oct. 17-18, 1961 in Sacramento. **Board Chairman:** Abraham Hoffman, D.S.C., 2320 Sutter St., San Francisco, Calif. **Executive Secretary:** Mr. Wallace Thompson, 1021 O St., Sacramento 15, Calif.

Colorado

Colorado State Board of Chiropody Examiners. **Board President:** Dr. G. F. Helbig, 327 Logan St., Denver, Colo.

Connecticut

The Connecticut Board of Examiners in Chiropody. **Board Secretary:** Dr. F. J. Ruggiero, 3 South Main Street, W. Hartford 7, Conn.

Delaware

The State Board of Chiropody Examiners of Delaware. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dover, Dela.

District of Columbia

The Board of Podiatry Examiners of the District of Columbia will meet for examination semi-annually July 1961. **Board Secretary:** Harry L. Hoffman, Ph.G., D.S.C., Dept. of Occupations and Professions, 1740 Massachusetts Ave., N.W., Washington 6, D. C.

Florida

The Florida State Board of Chiropody Examiners. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

Georgia

The Georgia State Board of Podiatry Examiners. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

Idaho

The Idaho State Board of Chiropody-Podiatry. **Board Secretary:** Dr J. E. Franden, 412 Eastman Bldg., Boise, Idaho.

Illinois

The Illinois Chiropody Examining Committee will meet for reciprocity and examination in June 1961 at 160 No. LaSalle St., Chicago, Ill. **Superintendent of Registration:** Fredric B. Selke, Room 109, State House, Springfield, Ill.

Indiana

The Indiana State Board of Podiatry Examiners. **Board Secretary:** P. T. Lamey, M.D., 422 Citizens Bank Bldg., Anderson, Ind.

Iowa

The Iowa State Board of Chiropody Examiners. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

Kansas

The Kansas State Board of Podiatry Examiners. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 812 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. N. Nash, M.D., 864 New Brotherhood Bldg., Kansas City, Kansas.

Kentucky

The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 4140 Shelbyville Rd., Louisville 7, Ky.

Louisiana

Louisiana State Board of Medical Examiners. **Board Secretary:** Edwin Lawson, M.D., 930 Hibernia Bank Bldg., New Orleans 12, La.

Maine

The Maine Board of Examiners in Chiropody and Podiatry. **Board Secretary:** Daniel A. Hanley, M.D., Box 637, Brunswick, Me.

Maryland

The Maryland Board of Chiropody Examiners. **Board Secretary:** Dr. S. Jack Kieger, 408 S. Division St., Salisbury, Md.

Massachusetts

The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at Room 33, State House, Boston, Mass. **Board Secretary:** Robert M. Quinn, D.S.C., 16 South St., Pittsfield, Mass.

Michigan

The Michigan State Board of Registration in Chiropody will meet for examination in June of each year. **Board Secretary:** Dr. Albert G. Kalin, 24453 Grand River Ave., Detroit 19, Mich.

Minnesota

The Minnesota Board of Chiropody Examiners. **Board Secretary:** Dr. Palmer H. Goulson, 612 Southdale Medical Bldg., Minneapolis 10, Minn.

Mississippi

The Mississippi State Board of Health. **Board Secretary:** Archie L. Gray, M.D., Box 1700, Jackson, Miss.

Missouri

The Missouri State Board of Chiropody will meet April 28, 1961 in Jefferson City, Mo. **Board Secretary:** Frank Fulkerson, 611 Clay St., Chillicothe, Mo.

Montana

The Montana State Board of Chiropody-Medical Examiners will meet when the need arises for reciprocity or examination at the Capitol Bldg., Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First National Bank, Bozeman, Mont.

Nebraska

The Nebraska State Board of Examiners in Chiropody. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

Nevada

The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 No. Arlington St., Reno, Nev.

New Hampshire

The New Hampshire Board of Registration in Chiropody. **Board Secretary:** Edward W. Colby, M.D., 61 S. Spring St., Concord, N. H.

New Jersey

The New Jersey State Board of Medical Examiners meets semi-annually for examination on the third Tuesday, Wednesday, Thursday and Friday of June and October. **Board Secretary:** Royal A. Schaaf, M.D., 28 West State St., Trenton 8, N. J.

New Mexico

The New Mexico State Board of Podiatry will meet for examination July 15-16, 1961. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N.E., Albuquerque, N. M.

New York

The New York State Board of Podiatry Examiners. **Board Secretary:** James O. Hoyle, Ed.D., 23 S. Pearl St., Albany, New York.

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References: (1) Kaindl, F.; Samuels, S. S.; Selman, D., and Shaftel, H.: Angiology *10*:185-192 (Aug.) 1959. (2) Samuels, S. S., and Shaftel, H. E.: J.A.M.A. *171*: 142-144 (Sept. 12) 1959. (3) Kraucher, G.: Prakt. Arzt *11*:325-329, 1957. (4) Birkmayer, W., and Mentasti, M.: Wien. med. Wchnschr. *108*:395-396 (May 3) 1958. (5) Clarkson, I., and LePere, D.: Detailed report in Mead Johnson research files. (6) Billiottet, J., and Ferrand, J.: Sem. méd. *34*:635-637 (May) 1958. (7) Singer, R.: Wien. med. Wchnschr. *107*:734-739 (Sept.) 1957.

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State Board *(Cont.)*

North Carolina

The North Carolina State Board of Chiropody Examiners. **Board Secretary:** Robert W. Getchell, D.S.C., P.O. Box 796, Goldsboro, N. C.

North Dakota

The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination at call at 301 Black Bldg., Fargo, N. Dak. **Board Secretary:** Joseph E. O'Brien, D.S.C., P.O. Box 872, Bismarck, No. Dak.

Ohio

The Ohio State Medical Board. **Examiner in Chiropody:** H. M. Platter, M.D., 21 W. Broad St., Columbus, Ohio.

Oklahoma

The Oklahoma State Board of Chiropody will meet for examination when necessary, in June and September and other times as needed. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

Oregon

Oregon State Chiropodists' Examining Board. **Board Secretary:** Richard H. Wilcox, M.D., 914 State Office Bldg., Portland, Ore.

Pennsylvania

Pennsylvania State Board of Chiropody Examiners will meet for examination in July, 1961, at the Education Bldg., Harrisburg, Pa. **Board Secretary:** Dr. Jack S. Pincus, 26 N. 3rd St., Harrisburg, Pa.

Rhode Island

The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

South Carolina

The South Carolina Board of Podiatry Examiners will meet for reciprocity and examination at the discretion of the Board. **Board Secretary:** Dr. James D. Hill, 122 W. Whitner St., Anderson, S. C.

South Dakota

The South Dakota State Board of Chiropody Examiners will meet at the discretion of the Board. **Board Secretary:** Viola Marr, 115 N. Main Ave., Sioux Falls, S. D.

Tennessee

The Tennessee Board of Registration in Chiropody. **Board Secretary:** Stephen A. Lamm, 3355 Poplar Ave., Memphis, Tenn.

Texas

The Texas State Board of Chiropody Examiners. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple, Tex.

Utah

The Utah State Board of Chiropody Examiners. **Board Secretary:** Ward A. Burbidge, 1015 Medical Arts Bldg., Salt Lake City, Utah.

Vermont

Vermont Chiropody Association. **Board Secretary:** Gray S. Clark, Service Bldg., Rutland, Vt.

Virginia

Virginia Board of Medical Examiners. **Board Secretary:** Russell M. Cox, 509 Professional Bldg., Portsmouth, Va.

Washington

The Washington State Chiropody Examining Committee usually holds Basic Science and Chiropody examinations the first and/or second week in January and July at the University of Washington, Seattle, Wash. **Board Secretary:** Thomas A. Carter, Administrator, Department of Licenses, Olympia, Wash.

West Virginia

Medical Licensing Board of West Virginia. **Board Secretary:** N. H. Dyer, M.D., 1800 E. Washington St., Charleston, W. Va.

Wisconsin

The Wisconsin State Board of Examiners. **Board Secretary:** Roy M. Cowen, 2018 E. North Ave., Milwaukee 2, Wis.

Wyoming

The Wyoming State Board of Registration in Chiropody-Podiatry. **Board Secretary:** Dr. J. W. Scott, 21 East Works St., Sheridan, Wyo.

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1. Sokoloff, O.: A.M.A. Arch. Dermat. and Syph. *64*:754, 1951. 2. Van De Erve, J.: A.M.A. Arch. Dermat. and Syph. *68*:572, 1953. 3. Bleiberg, J.: personal communication. 4. Tobey, J.: personal communication.

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10:30	Harriet Nelson	Inflamed nai_ grooves ✓
11:00	Elmer Spoff	Shoe dermatitis ✓
11:30	Ed Dunn	Callus ✓
12:00	P.M.	
1:30	James Taylor	[illegible]ema ✓
2:00	Allen Jackson	Ro[illegible]xamination
2:30	Edith Ramont	Varic[illegible]er ✓
3:00	Rita Wilbourne	Stasis [illegible]is ✓
3:30	Jess Sweem	[illegible]ergic e[illegible]
4:00	Myrtl[illegible]	[illegible]p care ✓
4:30		
5:00		
5:3[illegible]		
6:3[illegible]		
7:00		
7:30		
8:00	Filip[illegible]	
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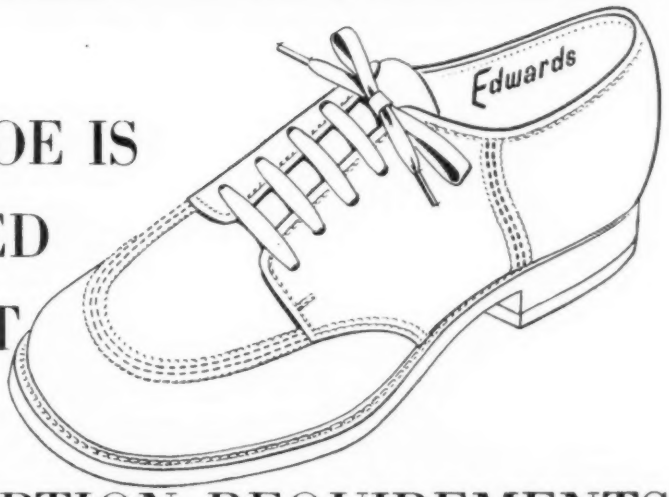

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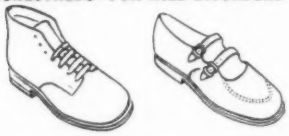

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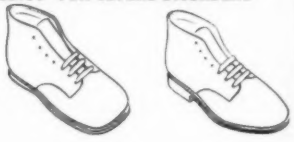

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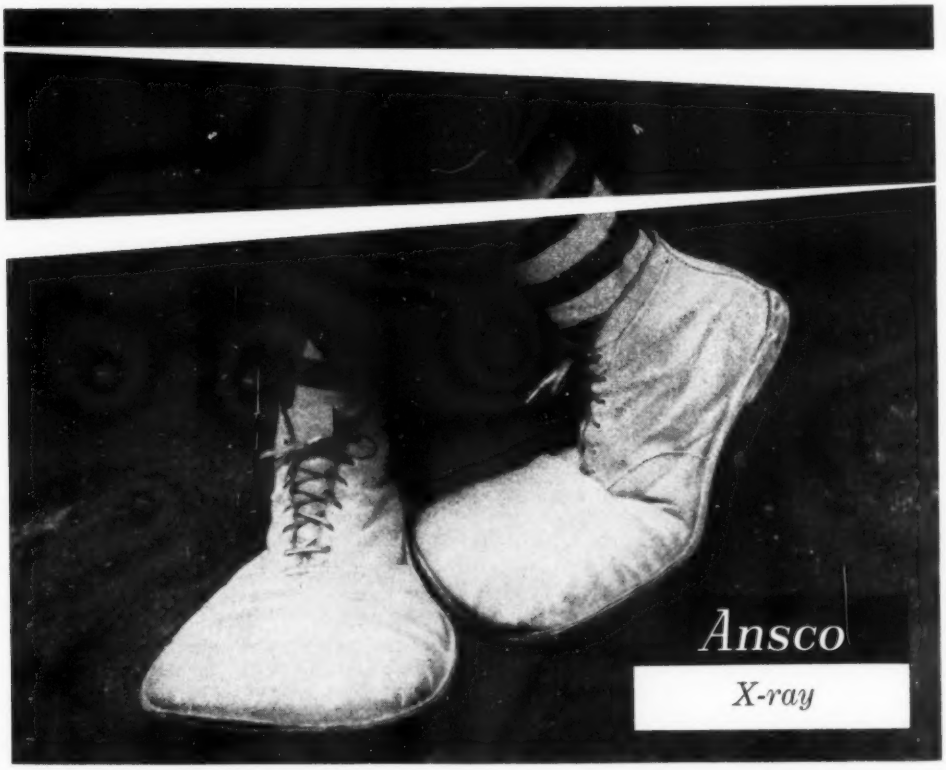

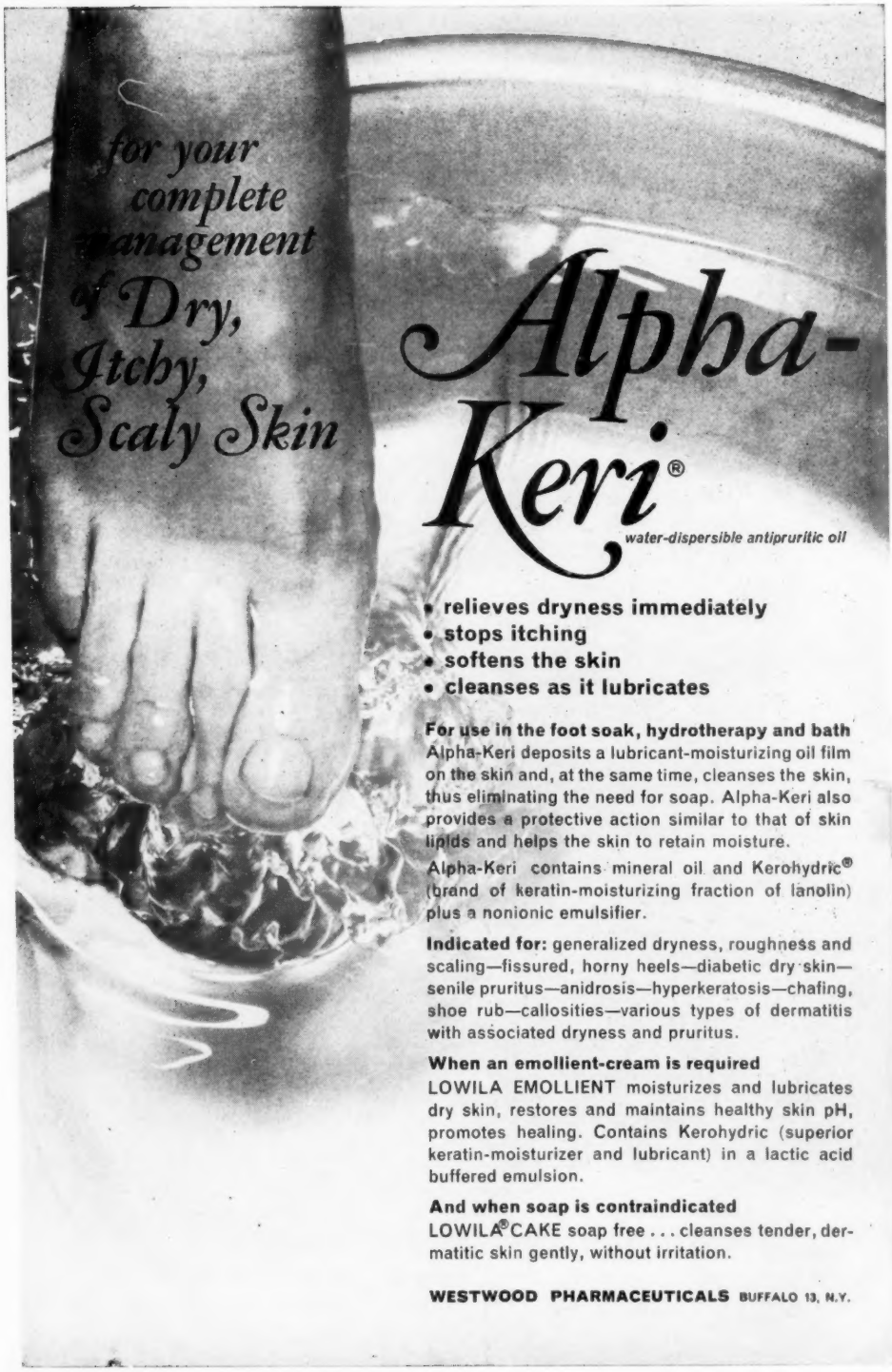
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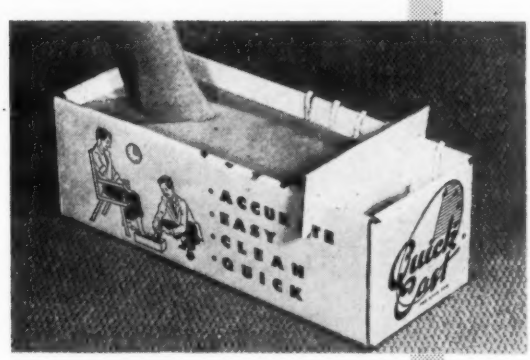

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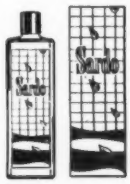
30 Diabetics	Marked Improvement
3 Pompholyx	Moderate Improvement
8 Eczematoid Dermatitis	Marked Improvement
12 Radiation Dermatitis	Slight Improvement
8 Non-specific Dryness and Scaliness	Marked Improvement



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The Therapeutic Use of a Corticosteroid-Antibiotic-Enzyme Ointment in Common Foot Lesions*

Morton H. Walker, D.S.C.

MEDICATIONS used in podiatry vary from a prescription containing many drugs given with the hope that one or more of them may prove effective to the other extreme of a single, specific drug the response to which is frequently considered pathognomonic of a disease. Between these two types is one in which a vehicle holds a principal drug together with adjuvants and correctives. This paper considers Chymar Ointment ® which contains several ingredients that are specific and collective in their action. It is effective against many skin conditions to control inflammation, to eliminate and prevent infection, and to clean wounds.

The Composition and Action Of Chymar Ointment

Formula – Each gram of Chymar Ointment contains:

Hydrocortisone diethylaminoacetate hydrochloride—1.25 mg.

Neomycin Palmitate – 3.5 mg. base activity.

Proteolytic Enzymes supplied by a mixture of pancreatic enzymes – 10,000 Armour units.

Base, water miscible—Q.S.

The Anti-Inflammatory Properties

Hydrocortisone diethylaminoacetate hydrochloride is a corticosteroid, extremely effective as a local anti-inflammatory, anti-allergic and antipruritic agent.

Regardless of the cause of a skin lesion, be it a mechanical, thermal or chemical injury, a bacterial invasion, or an allergic reaction, there is always local cellular inflammation present. Hydrocortisone preparations, and particularly hydrocortisone diethylaminoacetate hydrochloride, applied topically, possess the ability of preventing and reducing cellular inflammation. When noxious substances are removed, or the cells protected from them, normal physiologic processes can function and wound healing proceeds in a normal manner.

The important role of topically applied

® Chymar Ointment is a proteolytic enzyme with Neomycin and hydrocortamate, supplied for this study by Armour Pharmaceutical Company, Kankakee, Illinois, through the courtesy of J. A. Hubata, M.D.

* Paper submitted in the William J. Stickel Annual Awards for Research in Podiatry-Chiropody for 1960. Presented at the Annual Meeting of the A.P.A. held at the Drake Hotel, Chicago, Ill., August 1960.

hydrocortisone in a variety of skin lesions has been well established [1, 2, 3, 4, 5, 6, 7]. In a recent study, Robinson, Strahan and Robinson[8] demonstrated that a hydrocortisone diethylaminoacetate hydrochloride ointment was twice as effective as hydrocortisone free alcohol ointment. This is possibly due to the fact that the hydrocortamate is lipophobic and is also 400 times more soluble in water than hydrocortisone free alcohol. These investigators also demonstrated that an ointment of 0.5% hydrocortisone diethylaminoacetate hydrochloride and 0.5% Neomycin was very effective in eradicating secondary pyogenic infection.

Hydrocortisone diethylaminoacetate hydrochloride gives a prompter relief from pruritus, since relief from itching and reduction in erythema was obtained in all of the 90 patients treated.[9]

One would not expect side effects from a preparation containing 0.5% hydrocortisone diethylaminoacetate hydrochloride. Indeed, the possible absorption effects of this corticosteroid were studied by Robinson, Strahan and Robinson.[10] No appreciable change was noted in the total eosinophil count of 17-ketosteroid urinary excretion studies indicating that such a 0.5% preparation could be applied topically without incurring corticoid side effects. Nor does hydrocortisone significantly modify the rate of wound healing.[11]

Observations indicate that pancreatic proteolytic enzymes may have an inherent anti-inflammatory effect. Certainly it appears that the removal of necrotic tissue and debris by the enzyme permits the steroid to function more efficiently.

Combinations of corticosteroids and antibiotics are extremely effective clinically in responsive dermatoses likely to be complicated with pyogenic bacteria.[12, 13, 14, 15, 16]

The Anti-Infective Properties

Neomycin, the antibiotic in Chymar Ointment, is very effective against gram-negative and gram-positive bacteria. Allergic reactions to Neomycin are rare and it is non-sensitizing and does not interfere with wound healing.

The Neomycin in Chymar Ointment is in the form of the palmitate. This is a new therapeutic form of Neomycin; it has the advantage of having far greater activity than a comparable amount of Neomycin in the form of the sulfate.

Fungi and organisms susceptible to Neomycin are: Candida albicans, Cryptococcus neoformans, Microsporum audouini, Microsporum gypseum, Sporotrichum schenkii, Trichophyton mentagrophytes, Trichophyton rubrum, Trichophyton tonsurans, Hormodendrum pedrosoi, Allescheria boydii, Microsporum canis, Torulopsis utilis, Rizopus nigricans, A. aerogenes, S. typhosa, E. coli, H. influenzae, C. diphtheriae, H. pertussis, K. pneumoniae, Pr. vulgaris, Pr. aeruginosa, S. schott (para B), Sh. paradysenteriae, M. pyogenes Var. albus, M. pyogenes Var. aureus, M. pyogenes Var. citreus, M. pyogenes Var. epidermidis, Str. viridans, Str. hemolyticus, Str. pyogenes, Str. faecolis, D. pneumoniae, Cl. perfringens (ATCC), Staphylococcus Group.

The effectiveness of the antibiotic is enhanced as the progressive cleansing effects of the proteolytic enzymes are manifested.

The Debriding Properties

The enzymes are a combination of purified mixture of pancreatic enzymes, trypsin and chymotrypsin; in addition, desoxyribonuclease and amylolytic activity are also present. The primary action of the proteolytic enzymes is to digest and remove necrotic tissue, debris and crusts—to debride and cleanse wounds and remove foul odors. However, it is believed that trypsin has a favorable effect on wound healing[17] and some feel that the proteolytic enzymes also have a local anti-inflammatory action.

The Base

Chymar Ointment has a specially prepared, water miscible base. It has a very good spreading property; it is nontoxic and nonallergenic. The base is one that gives optimal release of medicaments for therapeutic effect.

Toxicity

In animal tests, Chymar Ointment has been applied every other day for 10 or more applications to the shaven and abraded skin of guinea pigs. Two weeks after the acute experiment was completed, the animals were challenged by reapplication of Chymar Ointment to the same areas. There were no indications of allergic or antigenic reactions.

The standard irritation tests on the intact and abraded skin of rabbits revealed no erythema or edema. No local or systemic reactions were observed.

In the concentration used, the mixture of pancreatic enzymes is not irritating nor does experience to date indicate that it will adversely affect living tissue.

General Clinical Results

Clinical results with hydrocortisone diethylaminoacetate hydrochloride and Neomycin—Welsh[18] reported on the treatment of 39 patients treated with an ointment containing hydrocortisone diethylaminoacetate hydrochloride and Neomycin concluding that this steroid was more effective than hydrocortisone free alcohol or hydrocortisone acetate.

Robinson, et al.[19] used 0.5% hydrocortisone diethylaminoacetate hydrochloride plus Neomycin 0.5% in the treatment of 549 patients with various dermatoses complicated by secondary pyogenic infections. Welsh[20] treated a wide variety of skin lesions.

Indications

Chymar Ointment is indicated in certain skin lesions, especially dermatoses complicated by secondary pyogenic infection, inflammation and pruritus. This includes such general conditions as: Abscesses, Acne, Actinica dermatitis and eczematization, Atopic dermatitis, Boils, Burns, Cervical erosions, Cheilitis exfoliativa, Contact dermatitis, Corns, Diaper dermatitis, Eczema —especially infected, Eczematoid dermatitis, chronic infectious, Eczematoid dermatitis, chronic with superimposed impetiginous infection, Erythema multiforme, Fissures, Herpes simplex, Impetigo, Insect bites, Intertrigo, Lacerations, infected, Nummular eczema, Otitis externa, Paronychia, Poison ivy dermatitis, Pruritus ani and vulvae, Psoriasis, Pustular bacterid, Radiation dermatitis, Seborrheic dermatitis, Stasis dermatitis, Ulcers, decubitus, diabetic, stasis or varicose, Varicella.

Contraindications—There are no known contraindications, but it is not to be used as an ophthalmic ointment. A slight stinging sensation may be experienced on first application of proteolytic enzymes. The action of Chymar Ointment may be stopped by irrigation with water.

Dosage—Chymar Ointment is applied once or twice a day directly to the lesion and covered with gauze. Whereas small and acute wounds will probably show improvement in a few days, large wounds, or wounds with considerable tissue necrosis will require more prolonged therapy.

Clinical Study

More than 800 applications of Chymar Ointment were utilized in the eradication of foot and leg problems involving acute, subacute and chronic infections and inflammations. However, before embarking on this broad survey of clinical and home usage tests, a series of routine patch tests was carried out on 100 people picked at random. The age group varied between 5 years and 80 years with the group between 25 to 50 comprising the greatest number. Male and female patients were divided almost equally in the series. The ankle was picked as the site of testing. No untoward effects occurred as far as this observer could determine.

In evaluating Chymar Ointment, the following classification was used: "excellent" indicates a remission within a reasonable time; "good" indicates marked improvement; "fair" indicates relief of pruritus and/or objective improvement only while Chymar Ointment therapy was continued.

Tylomata and Helomata: About 150 applications of Chymar Ointment alone were made to corns and calluses following their routine reduction, especially in those cases

where there was marked inflammation. In almost all cases the inflamed enucleation was free of symptoms within 3 days. Protective circular pads were used wherever needed and the ointment placed within the cutout hole with a wisp of cotton covering it. Also, the unction kept calluses soft, pliable and painfree between office visits when used by the patient periodically at home. Results were excellent.

Local Abscesses: Infected corns were treated by the direct, local application of Chymar Ointment in 26 cases. Most cases were free of infection within 3 days with the longest case going to 5 days (see Fig. 1). Results were good.

Fig. 1—Infected corn. Upper before, lower one day after one application of Chymar Ointment.

Allergic Dermatitis: The intact skin may tolerate many agents which, when applied to abrasions, will produce a skin eruption. Eight cases of contact dermatitis caused by adhesive tape were treated with Chymar Ointment over a period of 7 days in most instances. Results were excellent in every case (see Fig. 2).

Inflamed Nail Grooves: Following the palliative removal of the offending portion of nail, 38 patients were treated with Chymar Ointment and packed with cotton in the nail groove. Within 24 hours all were free of pain. Results were excellent.

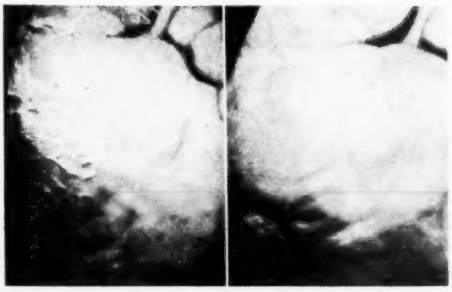

Fig. 2 — Contact dermatitis (rubber cement). Left before, right 3 days later, after six applications of Chymar Ointment.

Electrocautery Ulceration: Following desiccation or fulguration for verruca plantaris, 12 people were continuously dressed postoperatively with Chymar Ointment. All cases were healed in from 4 to 9 weeks. Except for stinging in the beginning applications of Chymar Ointment on the raw, denuded areas, there was uneventful healing. Results were fair to good.

Miliaria or Prickly Heat: Was cleared within a 3-day period in one case of a 3-year-old child. Results were good.

Sunburn: Prolonged use of an ultraviolet lamp resulting in second degree burns was quickly brought under control in 2 days. Blisters disappeared after the first application. Two cases experienced prompt relief. Results were fair to good.

Acid Cautery: In the use of 60% salicylic acid with resultant tissue destruction, 10 cases were ameliorated, frequently after only one application of Chymar Ointment. Results were excellent.

Nail Removal: Following the loss of the big toenail by either trauma or surgical removal as in the case of onychomycosis, Chymar Ointment dressings proved efficacious in 12 cases. There was stinging of the area after the local anesthetic wore off, but this disappeared within 8 hours. Relief and complete healing followed in most cases by the end of the 10th day after surgery. Results were good.

Epidermophytosis: The mild, anti-inflammatory action of Chymar Ointment was instrumental in acting as a soothing palliative in angry, acute ringworm exascerbations. Any secondary pyodermic infections were swiftly brought under control and although the medication is not specifically fungicidal it does prepare the invaded area to accept the caustic effects of topical antifungal remedies. (A perfect combination would seem to be oral griseofulvin and Chymar Ointment.) The enzyme quality of the ointment tends to soften the crusts, scabs and scales of epidermophytosis. Twenty-two cases were relieved of symptoms in this manner. Results were excellent.

Paronychia and Onychia: Six patients with this complaint were put on warm boric acid soaks or potassium permanganate soaks every 4 hours for 2 days with application of Chymar Ointment dressings between soakings. This course of treatment proved itself adequate in each case upon return to the office for observation. Results were excellent.

Insect Bites and Stings: In five cases Chymar Ointment showed itself to be effective in relieving pain and pruritus after two applications on the average in an 8-hour period. Results were good.

Neurodermatitis: The pruritus and sometimes the infection from scratching were treated with Chymar Ointment. One case out of three did not respond, but the others were relieved within 1 week's time. Results were fair.

Heel Fissures: Continuous and prolonged usage of Chymar Ointment by the patient at home resulted in a softening and prevention of callus formation with a closing over of the fissure. In 3 of 11 cases, additional supportive measures were needed such as latex heel cups, but all responded positively to the medication usually within 2 weeks' time. Results were good to excellent.

Ulcers: Chymar Ointment was effective in healing four perforating ulcers, five varicose ulcers and nine diabetic ulcers. (See Fig. 3.) Healing time varied greatly depending upon the size, location, chronicity and depth. Eight other ulcers of assorted vintage still have not healed over a 3-month period and are continuing under treatment. Supportive therapy was used in the more severe cases. In treating the usual varicose ulcer, use is made of the venous heart dressing.

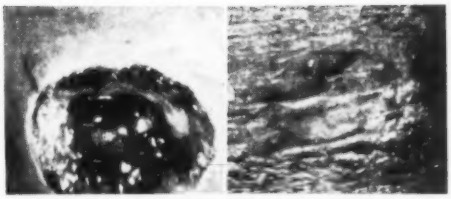

Fig. 3 — Trophic ulcer, diameter 2.5 cm. (left). Right, after 4 weeks of daily Chymar Ointment dressings.

It was found that Chymar Ointment prevented the formation of excessive granulation tissue with acceleration of epithelization. The water miscible base prevents adhering of the dressing to the ulcer. Chronic ulcers with such cicatricial tissue were softened, resulting in symptomatic relief from the drawing pains often associated with chronic ulcerations. In addition, limitation of motion which may or may not occur by the attending discomfort was decreased or eliminated. There was reduction in odor formation. Results were good.

Small Acute Wounds: Various minor contusions, lacerations, denuded areas, bullae, pustules, etc., were treated persistently with Chymar Ointment on a gauze pad after swabbing with benzene and alcohol, in more than 40 conditions. Elimination of the individual problem took place anywhere from 1 day to 2 weeks with the average at 7 days. Important in the wound healing process was the cleansing analgesic effect of the medication. The ointment verified its use as a first-aid remedy. Results were excellent.

Inflamed Bunions and Bursitis: Eight conditions of hallux valgus with or without bursal involvement were improved with proper padding, and application of Chymar Ointment. On the average it took 4 days to control the inflammatory process so that the foot could go without padding. Of course

in the case of an associated osteoarthritis with hallux valgus, improvement was not marked. Results were good.

Summary

This series of 380 patients whose foot and leg problems were treated by more than 800 topical applications of Chymar Ointment were benefited 97.5%. The conditions were: corns, calluses, local abscesses, allergic dermatitis, inflamed nail grooves, ulceration of electrocautery, miliaria, sunburn, acid cautery, complete nail removal, epidermophytosis, paronychia and onychia, insect bites and stings, neurodermatitis, heel fissures, ulcers of various types, small acute wounds and inflamed bunions and bursitis.

Prompt relief of acute pain was achieved in some cases within 24 hours and in most cases in 72 hours. Pruritus was controlled even faster with dissipation of symptoms frequently upon the immediate application of the medicament. Reduction of the cardinal signs of inflammation was demonstrated in most cases within 2 days, and often the tenseness or tenderness of an inflamed area owing to edema was reduced even in a shorter time.

The necrosis and tissue debris that impedes wound healing and provides culture media for bacteria was removed by the ointment without having to resort to mechanical debridement. This prevented the eschar from acting further as an inflammatory or bacterial-sensitizing agent. Necrotic and dead tissue was digested. Crusts, membranes, scales and foul odors were removed.

The drugs of this medication possess antibiotic, antiphlogistic and cleansing qualities toward open and closed traumas of the skin that make it safe, efficient and acceptable. It has shown itself to be nontoxic and nonsensitizing. In fact, it desensitizes inflamed areas so that they may accept more stringent topical applications.

Red, raw, denuded areas were reported to burn and sting with application of the ointment. These symptoms may have resulted from the debriding effects of the proteolytic enzymes. Also, the enzymes tend to break open blood clots in a new wound healing by secondary intention. It is not recommended that the ointment be used in this type of open area.

Conclusion

Chymar Ointment is a therapeutic tool that should be a part of the armamentarium of every doctor. The ingredients that comprise it are beneficial for a variety of conditions. Its antiphlogistic, antimicrobic and debriding qualities make it valuable in the stimulation of repair of most skin lesions, especially those affecting the lower extremities.

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Negative Galvanic Procedure for Morton's Neuralgia*

Morton Polokoff, D.S.C., F.A.S.C.R.

A brief review of the literature, tests for differential diagnosis and report of a new ambulatory negative galvanic electrosurgical procedure for liquefying and internal absorption of the tissue mass associated with Morton's neuralgia.

THIS is a report of an ambulatory procedure for liquefying and absorption of the tissue mass associated with Morton's neuralgia. Morton's neuralgia is synonymously known as Morton's toe, Morton's foot, Morton's disease, metatarsalgia and neuroma.

The satisfactory resolution of plantar verruca vulgaris and the destruction of nail matrix[1,2] by the employment of negative galvanic current (electrolysis) in hundreds of cases prompted experiments with this modality to destroy the hypertrophied tissue mass responsible for Morton's toe. Juettner[3] writes:

> "Negative (Cathodal) Electrolysis—The negative pole of a galvanic current attracts hydrogen and alkalies. If a needle, charged negatively, is thrust into raw meat, the needle will not stick. A whitish foam will issue from the point of insertion of the needle, the foam being composed of bubbles of hydrogen. The tissues near the point of insertion are softened and even liquefied. Therapeutically the process of destruction set up by negative galvanic electricity can be utilized in the treatment of manifold conditions."

Gratifying results were achieved in the Morton's neuralgia procedure. The operation is an ambulatory, routine office procedure with minimal postoperative reaction requiring little or no loss of work time for the patient. A perusal of the literature reveals the following references in approaching and treating this syndrome.

Jones[4] postulates that the sudden severe neuralgic pain characteristic of the condition is due to a compressing of the nerve twigs by the metatarsal heads, which have fallen out of their proper plane in the transverse arch and nipped the nerves between the head of a metatarsal bone and the ground. McElvenny[5] believes that Morton's neuralgia is caused by a tumor involving the most lateral branch of the medial plantar nerve. These tumors are neurofibromas or angioneurofibromas, and he advises excision of the tumor if symptoms are severe. Morton has advised excision of the metatarsal head if relief is not obtained by conservative therapy.

Hertzler[6] contends that the nerve-pressure theory advanced by Morton has no facts to substantiate it and that relief is not obtained by conservative therapy. Hertzler contends that this condition is due to inflammation of one or all of the three sets of bursae in the region of the metatarsophalangeal articulations. He advises obliteration of any inflamed bursae by curettement.

The writer is of the opinion that this condition is aggravated and influenced, if not due, to an interaction between branches

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of the nerves and osseous structures in this area. Further, this condition exists only in the presence of an improperly balanced foot. The writer joins Jones and Dudley Morton[7] in the belief that the mass is merely enlargement rather than a true neuroma.

Although the subjective symptoms of Morton's toe are clear-cut and definite, many cases are missed completely in the early stages when the pain is tolerable and lasts for brief periods (Christopher[8]). The advanced case is seldom misdiagnosed because of acute and prolonged pain in the usual circumscribed area. The patient's description of the symptoms is often misleading. Phrases used by the patient are as follows: "numb yet painful," "a cramp," "a hot burning," "an electric shock-like pain" and "a tingling radiating pain." Removal of the shoe and massaging the foot gives relief as may standing on a cold floor in the bare or stockinged feet.

Many mechanical adjustments to the shoe (Jones), the leather bars and arch supports (attempting to elevate a depressed metatarsal head) are temporary relief measures that influence the patient to attempt to live with this recurring pain. Many cases are carried along with temporary measures only to terminate in excruciatingly severe frequent attacks of pain and a highly nervous patient.

McElvenny[9] reports permanent cures in 11 cases with tumor excised in each case. Similar results are reported by Betts[10], Kaplan[11] and others.

Once a definite diagnosis of Morton's neuralgia has been established, immediate surgery or electrosurgery should be advised in the best interest of the patient. A telephone call at a very early morning hour from a hysterical patient crying for relief gives an idea of how severe Morton's neuralgia can be.

This paper describes a simple procedure applicable in everyday office routine enabling the practitioner to resolve a very recalcitrant condition. With thoroughness it is seldom necessary to repeat this electrosurgical procedure.

Diagnosis

Unfortunately there are no objective signs to aid in diagnosis. Close observation in scattered cases may show separation of the toes due to pressure of the mass. Radiographic findings are always negative. Repeated trauma to the nerve twig from the bony prominences causes increased localized proliferation around the nerve.

Morton's neuralgia must be differentiated from an arthritic metatarsophalangeal joint, inflamed bursa, ganglion or cyst.

Morton's neuralgia and an arthritic metatarsophalangeal joint or joints often co-exist in the same area. One condition may be mistaken for the other because of similarity of pain. The arthritic metatarsal joint is a continuing pain without sudden onset. It is important to clearly evaluate these cases to obtain a satisfactory result. The writer suggests the following diagnostic finger pressure tests.

Finger Pressure Test for Arthritis (Fig. 1): Squeeze the metatarsal joint between two fingers simultaneously from dorsum and plantar aspects. Compare the amount of tenderness or pain elicited by patient to similar pressure to other joints on the same foot or to the same joint on the other foot. A positive finding is strikingly evident by pain. Increased size due to inflammatory distension within the metatarsal joint capsule is often discernible. Heberdens nodes of the fingers are often concomitant findings; although the hand and foot may not have these similar arthritic joints. Certain joints of the imbalanced foot are subjected to greater trauma and thus become more symptomatic.

Lateral Pressure Test (Fig. 2): Apply pressure against the lateral sides of the metatarsal heads by gripping the entire forefoot and squeezing the heads together.

What may seem to be a simple heloma on the dorsum, between the toes or in any area of the toes, may in reality be the skin manifestation of an arthritic joint process, Locke[12]. The presence of Heberdens nodes on the fingers should alert the practitioner to possible arthritic activity in the feet.

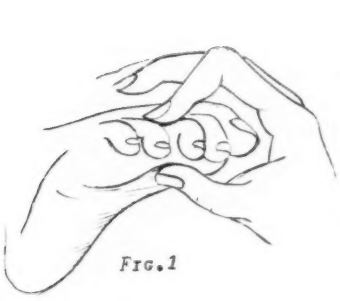
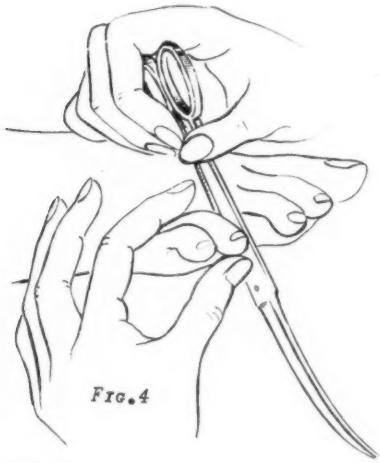


FIG. 1

FIG. 2

FIG. 3



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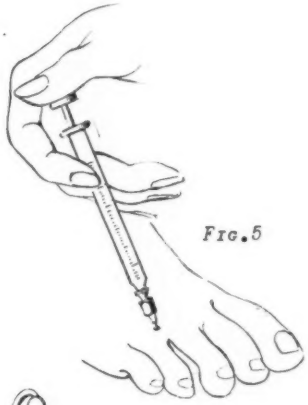

FIG. 5

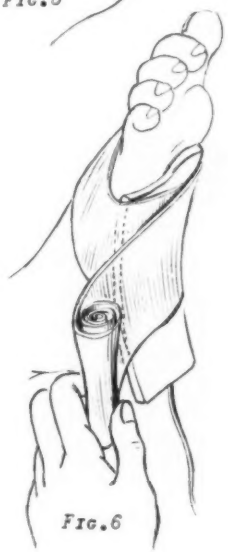

FIG. 6

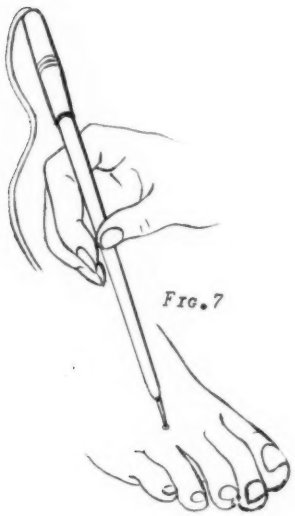

FIG. 7

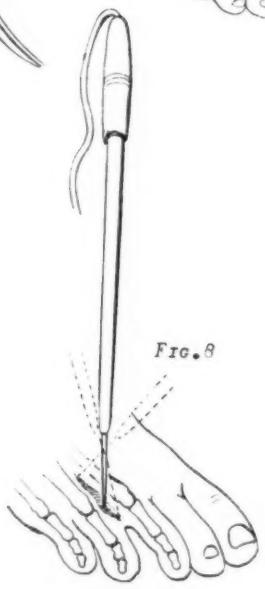

FIG. 8

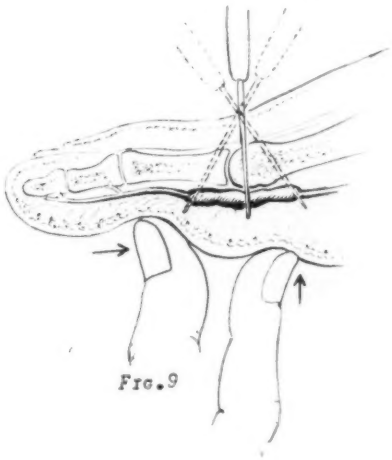

FIG. 9

Figs. 1, 2, 3, 4, 5, 6, 7, 8, 9—See Text.

Arthritic metatarsal and phalangeal toe joints usually proceed or accompany Heberdens nodes of the fingers, especially in feet that have structural defects. Orthodigital devices, foot balancing strappings, appliances, injection therapy and physical therapy are all important in treating the feet with structural defects and arthritic joints.

Inflammation of a bursa may co-exist with Morton's toe and arthritic joint or a ganglion or cyst. This common finding results from an overload to individual metatarsals[13]. Test for bursal inflammation by pressing soft pad of finger against the plantar surface staying close to the metatarsal head (Fig. 3). Make comparison tests with other metatarsals.

Ganglia occurring between the metatarsal heads are diagnosed by palpation. A cyst can easily be moved, is soft and has a grape-like character.

Questioning the patient often aids in establishing the diagnosis, yet where the patient's answers are indefinite, keep in mind that in the early stages the symptoms are elusive and spasmodic. The following questions are suggested:

1. Do you get this pain every day?
2. Does it occur on the same foot and in the same area?
3. Does it start mildly and build up in severity?
4. Does it start as soon as you stand each morning?
5. Can you be walking along and have it suddenly start with acute pain?
6. Does it ever start in bed, standing or in kneeling down position?
7. Will removal of the shoe give immediate relief or is rubbing or manipulation necessary?
8. Does pain radiate to end of a certain toe or nail groove?
9. Does it ever radiate up the instep?
10. Has the pain increased in severity?
11. Does the pain come without warning and with immediate sharp intensity?
12. Does the pain last for a longer duration?
13. Are certain shoes more comfortable?
14. Are higher heels a factor?

Palpation Can Be Most Important in Establishing a Positive Clinical Finding (Figs. 2 and 4): Press with fingers to push the mass between the metatarsal heads and with the other hand grasp and press all metatarsal heads together. Feeling the sizable mass slipping away as the head presses against it with pain is a positive finding. Comparison to other intermetatarsal areas with negative finding will confirm test.

Negative Galvanic Procedure

Materials required are: Galvanic Unit, Needle Holder, Birtcher Needle "Spear" (Remove white collar), Syringe 1 to 5 cc., Needle 26 gauge 1 inch, Electrode wet 4x5 inches, Tensor® bandage 3 inch x 2¼ yards, Negatan.

Preoperative Medication: An antihistaminic such as Benadryl®[1] 25 mg. or Dimetane®[2] 4 mg. to counter possible histamine reaction is suggested. Sedation or analgesia medication is not necessary.

Scrub: From tip of toes to ankle give a thorough 4-minute pHisoHex®[3] scrub. Allow a film of pHisoHex to remain on the skin.

Anesthesia: Dorsally at the area over the interspace where the tissue mass lies the anesthesia needle is injected first superficially to obtain a wheal, then deposited to envelop the tissue mass (2% Xylocaine®[4] with 1 to 100,000 Epinephrine®[5] solution). Anesthetic agent of choice. A total volume of 2 cubic centimeters is usually adequate (Fig. 5). Allow 5 to 10 minutes' time for spreading of the anesthetic to obtain good anesthesia.

Positive Electrode: A moistened electrode approximately 4x5 inches in size is securely fastened to the plantar surface of either foot with the 3 inch x 2½ yards Tensor bandage (Fig. 6). Any sensitivity under

®[1] Parke, Davis
®[2] Robins
®[3] Winthrop
®[4] Astra
®[5] Burroughs, Wellcome & Co.

wet electrode when current is on means the bandage is too loose or that a skin abrasion is present beneath the electrode. If this is so, either tighten bandage or change site of electrode to the other foot as necessary.

Negative Galvanic Needle: Insert the needle into the skin opening produced by anesthesia injection (Fig. 7). Spread the toes contiguous of involved metatarsal interspace widely to separate the metatarsal heads. Turn on the galvanic unit and advance to 5 milliamperes. Current volume is determined by advancing the milliamperage until the patient feels heat, then reduce current by two or three milliamperes to patient tolerance (five to ten milliamperes). Length of time required to dissolve the tissue mass is determined by tissue resistance to needle movement. At the start the insertion of the needle meets with resistance and pressure is required to get deep penetration. Still more pressure is required to push the needle in a pendulum motion between the metatarsal heads (Fig. 8). In this technique, the needle is inserted shallowly at first and depth is progressively increased until it reaches the depth of approximately 1 inch or near the plantar skin. Pressure with the thumb from the plantar surface will push the growth into the path of the needle (Fig. 9). Complete softening by electrolysis requires approximately 8 to 12 minutes, depending on tissue density. Less dense tissue requires less time. Withdraw the needle only after the current has been shut off. The dressing consists of a sterile 3x3 gauze pad folded double and fastened with elastic adhesive.

Instructions to Patient: After 24 hours, soak foot in warm solution of Epsom salts (1 tablespoon to 1 quart of water) for 15 minutes. Repeat three times daily.

The exudate formed by dissolution of the tissue is mostly absorbed into circulation (warm foot soaks hasten this absorption). Very little drainage is noticed on the bandage when the dressing is changed. Change the dressing every 3 or 4 days during the first 2 weeks and then weekly. Physical medicine to stimulate circulation is started on the third visit. All dressings are removed when an eschar forms.

Foot Balancing: Orthopedic balancing of the forefoot is started as soon as tenderness from the electrosurgical procedure has subsided. Forefoot balancing consists of a dense felt platform placed under the hypermobile first segment. The thickness of the platform is progressively increased till the first segment carries its share of weight.

Patient is asked to report any recurrence of pain of Morton's neuralgia. When and if even mild symptoms occur, it means that the tissue mass was not entirely dissolved. A repetition of the procedure is advised if definite symptoms recur within 3 or 4 weeks.

Some Typical Cases

Case No. 1—Mr. S. Y., age 32, clothing salesman, stands most of the day. Chief complaint, typical neuralgia symptoms of Morton's toe on left foot. Had previous treatment employing arch support, metatarsal wedges and injections of procaine hydrochloride without any permanent result. Examination by palpation and lateral pressure revealed a fluctuating mass between the third and fourth metatarsal heads of the left foot where the patient has his symptoms. Duration of this condition has been 5 years. Other findings are a hypermobile first segment and an inflamed bursa under second metatarsal heads bilaterally. The negative galvanic procedure was used to dissolve the tissue mass. One week later foot balancing was started which was completed with a celastic shell appliance containing a first platform. The patient has been completely symptom-free since the negative galvanic procedure was employed.

Case No. 2—Mrs. B. C. Pain occurs only when at work as waitress, always in same area of left foot between the third and fourth metatarsal heads. This patient was treated with negative galvanic electrosur-

gery three times with diminution of the pain for only short periods of time. The patient was hospitalized for open surgery. A completely encapsulated mass was removed. Pathologic report was fibroma. After 2 weeks the pain returned. Injection of hydrocortisone acetate into the fourth metatarsal space was tried. Patient returned in 1 week saying this was the first time she felt relief in the area. A few more injections were given till all symptoms left. The patient returns for observation every 3 months.

Case No. 3—Mrs. M. B., age 60, chief complaint a pinching in the right third toe existing for 4 months. Pain was continuous all day. Palpation revealed a mass slipping between the metatarsal III and IV. Patient must take shoes off for relief. Additional findings are a structural forefoot imbalance with extreme hypermobility of the first segment and a minimal hypermobility of the fifth segment bilaterally. Plantar callus was marked under second, third and fourth metatarsals. Patient experiences night cramping in calf muscles. Bursa under fourth right metatarsal sensitive to pressure. Chronic colitis existing for several years. Hemoglobin 11.5 gm. per 100 mg. Patient has a large-sized foot (11½B) which has been forced into small shoes most of her life. The negative galvanic electrosurgical procedure was performed on the right foot. Patient was able to return to work on the following day. She could wear regular shoes. Because her job consisted of standing, a Fay bar was placed under her right shoe to reduce the weight at the ball of the foot. Platform balancing of the forefoot was started on the second week. There has not been any recurrence of the Morton's neuralgia since the operation 10 months ago.

Case No. 4—Mrs. S. R. Typical bilateral Morton's neuralgia with right more severe. Patient is overweight about 100 pounds. The pain has increased in the last 2 months till it has become unbearable. Examination revealed normal findings with no excrescences on the feet. There was a mild hypermobility of the first segment bilaterally. Palpation test revealed a mass that slipped between the metatarsals III and IV.

The negative galvanic procedure was performed on both feet. The patient has been symptom-free for 1 year when seen at her last check-up.

Summary

An ambulatory routine office procedure as an alternative to surgery has been described. As with all procedures, this technique requires thoroughness in its application. For best results, an extra minute or two of applying the negative galvanic current is advisable. However, there is little or no patient resistance to a repetition of the procedure because of the minimal postoperative pain or inconvenience. Some illustrative case histories have been cited.

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The only thing we have to fear is fear itself.

—*Franklin D. Roosevelt*

A Device for the Prevention of Leg Congestion*

Milton D. Roven, Pod.D., F.A.P.

In the treatment or prophylaxis of foot and leg pathology, elevation of the extremity at some phase of treatment is frequently indicated. In fact, elevation to prevent venous stasis has become important today to neutralize the effects of minimal walking and other exercise.

It has been shown that there is a decided danger of venous and arterial thrombosis of the leg vessels after prolonged sitting without elevation of the lower extremities or movement of the legs. In World War II, 21 sudden deaths from pulmonary embolism were reported by Simpson[1] in persons in or leaving air raid shelters. The cause was noted to be venous thrombosis of the legs resulting from long periods of sitting on chairs or benches with the edges compressing the veins. His account reveals the nature of the process in the deep veins of the calf, notably in how a few hours of sitting still, a fatal thromboembolism may be set up, from a propagation of clot and pulmonary embolism.

Homans[2] showed the frequency of thrombosis of the deep leg veins after prolonged sitting, especially in automobiles.

Naide[3] has reported venous thrombosis in legs of tall men after long motor trips. His article suggests that prolonged dependency stasis, a state imposed by airplane flights, automobile trips, and even attendance at the theater is able unpredictably to bring on a thrombosis of this sort.

In another article Naide[4] cites cases of venous and arterial thrombosis caused by prolonged television viewing. Three patients developed major thrombosis in the legs, two in the veins with pulmonary embolism, and one in the femoral artery, following prolonged sitting in awkward positions while viewing television programs.

According to experiments, there is much difference in weight and hydrostatic pressure in the blood column of the veins of the legs (femoral veins), between the upright and the horizontal postures. In the former there is an almost uninterrupted column from the legs to the heart, exerting pressure upon the femoral veins, likely to distend them, if there is such a tendency in the individual. This column has been measured to correspond to a pressure of 175 cm. of water or to 15 cm. of mercury.

To counteract the effects of prolonged sitting or standing, the writer advised his patients to rest their feet on a hassock or footstool. These were found to be inadequate. Placing the feet and legs on a hassock might compress the veins of the calves thus predisposing to venous thrombosis. O'Neill[5] states that thrombosis is even more likely to occur when both of the legs rest on some sort of support causing injury to the endothelium. In addition, footstools were found to be generally too low and too uncomfortable. None of these devices encouraged motion of the feet or toes which was a most important factor.

What was required was a device that could elevate the extremities without pressing on the calves and at the same time encourage foot and toe movement by a rocking device. Compactness and portability were considerations to encourage use.

The author has developed a device consisting of a horizontal leg extension about 22 inches long and a vertical footrest about 23 inches high which is freely movable at its base because of a rocker arrangement. It tilts to the desired position and can be used with any height chair because it does not hook to the chair. Since the device can be rocked back and forth readily, the foot and toes are flexed and extended thus "milking" the calf veins frequently, keeping active the circulation of blood in the lower extremities. The pitch of the device does not allow compression of the calf. The feet are held in a slightly inverted position. The vertical footrest is so constructed with peg

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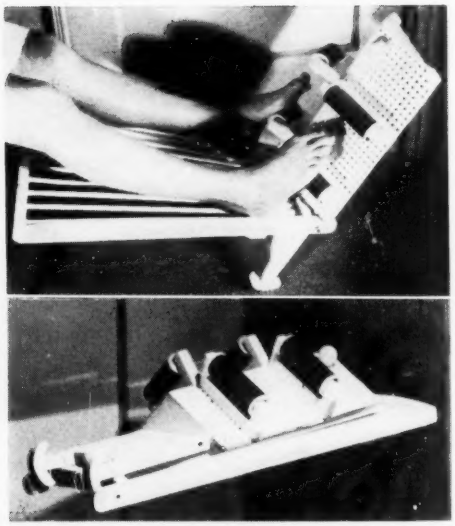

Fig. 1—Upper, Device in use. Only one set of rollers is being used. Note calves do not touch the legrest. Lower, Device collapsed for storage or moving.

holes that it allows for attachments to be interchanged at a particular section of the foot. The footrest encourages the foot to rest in an inverted position allowing flexion and extension of foot and toes. A ball attachment about ¾ of an inch in diameter can be set at the metatarsophalangeal articulations and the toes can be curled around the ball. This exercise helps increase the flexibility of the toe joints, strengthens the toe flexors and stretches the toe extensors.

In those cases where exercise and massage are indicated, four roller attachments consisting of movable pieces of sponge rubber can be placed on the vertical footrest for any area of the foot. For this purpose it can be used on weightbearing, by placing the vertical footrest on floor, activating the grasping mechanism of the foot. This can be particularly valuable in exercises prescribed for children.

Resistive exercises can be performed by placing the toes under a bar of the roller frame.

When the device is turned over, it can be used on the bed for the Buerger-Allen active vascular exercises.

The device may also be used in bed where prolonged bed rest is necessary. It has been shown that prolonged bed rest causes decreased blood flow, disuse atrophy, bone absorption and muscle wasting. Individuals immobilized for several weeks lose significant amounts of nitrogen, sulphur, calcium, phosphorous and potassium; creating metabolism, control of the circulation in the upright position, muscle mass and strength are also significantly impaired. Utilizing this device with its exercise attachments may nullify some of these ill effects.

Some of the conditions where this device may be of value are in the treatment of thrombophlebitis, varicose veins, postoperative foot surgery, stasis ulcer and diabetic ulcer of the foot. Anyone who is required to stand because of occupation, such as a sales person, dentist or surgeon, could use such a device to prevent venous pooling in the feet during the day.

Summary

A device which can be made at home is presented which maintains the lower extremities in an optimum position and facilitates therapeutic exercises. It is an aid in the treatment of patients requiring elevation. It also provides comfort and prophylaxis against venous stasis for those who must either stand or sit for prolonged periods of time.

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Clinically Speaking

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

A Modified Technic of Office Surgery for Hammer Toe

Seymour H. Blau, D.S.C.*

EXTENSIVE disability and suffering caused by hammer toes has led to considerable variations of the operative techniques. All procedures have the same basic aim and principle but vary in the type of incision, amount of phalanx removed, use or nonuse of Kirschner wire, and in preoperative and postoperative practice. DuVries[1] in his text "Surgery of the Foot" states, "there is an advantage in simplifying and standardizing the procedure in order to minimize postoperative complications and pain, and to make it possible to perform definitive surgery without hospitalization." Over the past 5 years we have developed and used the following procedure:

1. The condition is carefully evaluated by palpation, X-ray and medical history. The patient is examined medically, with particular attention to complete blood count, urinalysis, blood sugar, bleeding and coagulation time. Surgery is undertaken only if the findings are within normal limits or until abnormalities are corrected.
2. In order to allay apprehensiveness, 25 to 50 mg. of hydroxyzine ®[1] is prescribed at bedtime the day before surgery and the dose is repeated an hour before surgery, with 250 mg. of tetracyclineoleandomycin®[2] as prophylaxis against infection. In cases involving multiple hammer toes, ½ gr. of codeine and 50 mg. of demerol are also given.
3. Local block is induced by 1 percent Xylocaine®[3] and anterior and posterior tibial block is induced when two or more toes are to be operated on in the same foot.
4. A Z-plasty incision is made longitudinally over the dorsum of the phalangeal joint and carried down to the tendon and joint capsule.
5. The tendons are incised and the capsule opened with a Bard-Parker No. 15 surgical blade. Separation is accomplished with a small periosteal separator (freer) so that the head of the condyle is clearly visible. Bleeding is controlled either by hemostats or tourniquet.
6. The condylar heads of the proximal or middle phalanx are freed by incising each side of the capsule with a Bard-Parker No. 15 or No. 12 blade.
7. A 4 mm. osteotome is driven into the bone immediately posterior to the head of the condyle; a bone cutting forceps is then used to resect as much bone as is necessary to make the joint easily movable. The cavity is explored with the index finger in order to make certain that it is free of spicules. Tenotomy is accomplished with a Bard-Parker No. 12 surgical blade to permit the toe or toes to lie flat. The cavity is then flushed with sterile saline solution or 1 percent Xylocaine.
8. The ends of the tendons and the margins of the capsules are joined with interrupted sutures of chromic catgut 000 or 0000.
9. The Z-plasty skin incision is sutured with black silk 000. Neopan Cream®[4] (Panthoderm with Neomycin) is applied and the toe is held in proper alignment with a sterile Adaptic plastic®[5] 3 x 3 dressing and compression

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®[1] Supplied by Pfizer Laboratories as Vistaril®
®[2] Supplied by Pfizer Laboratories as Cosa-Signemycin®
®[4] U. S. Vitamin and Pharmaceutical Corp.
®[5] Johnson & Johnson

dressings with sterile sponges and wrapped with sterile adhesive gauze.

10. The whole foot is encased in a stockinet No. 3 or No. 4. The patient is given a comfortable cutout or surgical shoe.

Postoperatively the patient is placed on 25 mg. capsules of hydroxyzine (1 b.i.d. for 2 days) and 250 mg. capsules of tetracycline-oleandomycin for prophylaxis of infection (1 b.i.d. for 4 or 5 days). He also is given A.S.A. and codeine compound, ½ gr., to be taken 1 q. 4 h. for 3 days. When surgery has been extensive, the patient is instructed to remain in bed for a day or two and to keep the foot elevated if there is any sign of swelling or pain.

On the 3rd or 4th postoperative day the patient is visited at home, the dressing is removed, the area cleansed with alcohol, dried with sterile sponges, and the original dressing repeated. The dressing is again changed on the 6th day. The sutures are removed on the 8th or 10th day, at which time a smaller dressing is applied and the patient is then able to wear white socks or stockings and a comfortable shoe. It is important that the shoes fit properly. A simple dressing with Neopan, to be changed daily, is prescribed for the next few weeks.

Over 100 patients have been treated with this technique. Most were young adults; their ages ranged from 17 to 51, and the condition had existed from 2 to 20 years. A few had one hammer toe but most had one on each foot, many had a total of three, four or five. The condition was congenital in many of the multiple cases. (In each case one or more colleagues and scrub nurse assisted in the surgical procedure.)

Summary

1. There have been many methods used in correction of hammer toe surgery. A simple office procedure has been described.

2. No postoperative complications have resulted.

3. The medications prescribed caused no undesirable side effects.

4. Functional and cosmetic results were good in all cases.

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Equanil in Chiropody

Sam D. Zebrack, D.S.C.

Along with modern chiropody has come greater responsibility for the chiropodist-podiatrist, with all of this responsibility being directed toward the welfare of his patient. We cannot simply look at the patient's feet and derive an adequate mode of therapy for his problem: we must look at each patient as a separate entity within himself. In doing this we must consider the patient's anxieties and fears, his apprehensions to treatment.

"Apprehension" is defined by Dorland[1] as "anticipatory fear" and this fear is one of the biggest problems that the modern-day podiatrist must contend with in his everyday practice. The use of narcotics or barbiturates has long been employed by the profession pre- and postoperatively since they can act as "analgesic, hypnotic, antispasmodic, diaphoretic and narcotic"[2] and are useful for this purpose, as well as in the treatment of injuries.

However, the advent of the synthesis, by Ludwig and Piech in 1950, of 2-methyl-2-n-propyl 1-1,3 propandediol dicarbamate has given us a new method of approaching this problem, used successfully for this purpose by many practitioners for several years. Equanil®[1], a proprietary name of the drug, is effective as a skeletal muscle

®[1] Wyeth Laboratories, Inc.

TABLE I

Sex Age	Condition	State of Patient	Dosage	Effect
F. 32	Subungual hemorhage, traumatically induced.	Pt. extremely fearful of injection of anesthetic	400 mg.	Pt. giddy but showed little or no apprehension.
F. 63	Preoperative procedure for reduction of interdigital exostosis on lateral aspect of proximal phalanx rt. gt. toe.	Pt. requested something for "nerves."	400 mg.	Pt. drowsy and seemed unconcerned about surgical procedure.
M. 34	Trauma to 1st M-P articulation rt. foot, no evidence of fracture, but severe swelling; pt. unable to sleep at night.	Pt. claimed pain so severe he couldn't sleep.	400 mg.	Pt. able to sleep, severe anxiety over injury controlled, strapping immobilization adequate in treatment.
F. 17	Preop. for "Frost" excision of offending nail spicule.	Pt. has phobia of needles, and instruments.	200 mg.	Pt. extremely giddy but did not exhibit anxiety over injection of anesthetic.
F. 59	Preop. for soft tissue resection of offending lip, overlying rt. gt. toenail.	Pt. flushed and excited over having "Surgery" done.	400 mg.	Pt. calm and relaxed; treatment carried out without interference.
M. 13	Verruca plantaris left heel, to reduce by electrocautery.	Pt. nervous and hypersensitive over choice of treatment.	200 mg.	Pt. relaxed; treament carried out successfully.
M. 47	Infected onychocryptosis.	Pt. extremely nervous over treatment.	400 mg.	Pt. calm; spicule reduced and area drained.
F. 34*	Gouty lesion of 1st M.P. articulation, uric acid level of 11, complicated by secondary infection.	Pt. irrational and overly excited over outcome of her extremely swollen and tender leg and foot.	400 mg.	Pt. not totally relaxed but able to follow instruction now. *Pt. treated concomitantly by physician. Pt. calm and relaxed during procedure.
M. 19	Preop. for "Frost" reduction of onychocryptosis.	Pt. worried over injection of anesthetic.		
M 16	Infected onychocryptosis complicated by granuloma pyogenicum.	Pt. nervous and flushed over "cutting" of toe.	200 mg.	Pt. still slightly excited at onset of treatment, but relaxed during procedure.

relaxant and can play an important role in the managing of anxiety and tension.

It has been used over the past 2 years in this office in an attempt to avoid the use of narcotics and barbiturates and their side effects. Equanil was administered not only pre- and postoperatively but also in procedures involving treatment for traumatically caused injuries, for example in partial nail avulsions and fractures of the phalanges. The rationale of therapy is not to use this drug as a sedative or analgesic, which it is not, but to control fears of the patient involving possible further pain during treatment.

Indications for such therapy depend on the practitioner's interpretation of the emotional and anxiety state of the individual patient. It is known that "cardiac acceleration is common; dyspepsia and diarrhea often accompany fear; skin lesions and edema may occur with anxiety states."[3]

A tablet of Equanil is administered ½ hour prior to treatment. Table I tabulates our results in 10 cases.

It will be noted that 80 percent of the patients experienced calmness and relaxation, while the remaining 20 percent were helped by the administration of the drug. Twenty percent showed giddiness as a side reaction to and during a state of relaxation of emotional tensions regarding their treatment.

Fears regarding treatment can often

exaggerate the amount of pain that a patient will experience during therapy. Equanil, which is not a narcotic or analgesic, is a definite aid in overcoming these fears, relaxing the patient and minimizing the amount of pain during and after treatment. This paper is an effort to report findings which indicate that there is a place for the drug in our practices.

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Astrocytoma—A Case Report

G. W. Isenberg, D.S.C.

A YOUNG female, age 23 months, was brought to this office on April 19, 1960. The chief complaint was that she stumbled and had flat feet since walking. Duration of stumbling was 2 weeks and becoming worse.

Past medical history revealed a full term baby, normal delivery (9 lbs. 10 oz. at birth), and walking at 11 months, chickenpox in November, 1959, with no history of convulsions or trauma.

Physical examination revealed a highly sensitive, well-developed and well-nourished child. In observing her gait she would take several steps and then sit down and cry. The child walked with the hips externally rotated and feet abducted with tendency toward cavus-type foot. Frog test and Galeazzi's sign were negative and skin folds on thigh and buttocks were equal. A mild amount of genu varum was present bilaterally. Leg measurements were equal and no appreciable atrophy was noted in the extremities. Ankle could be hyperflexed ten degrees and there was slight pronation. All other joint motions were within normal limits. Neurologically she presented a broad-based ataxic gait. The deep reflexes were exaggerated bilaterally. Equivocal Babinski's sign was present bilaterally. Sensation was intact.

X-ray examination of pelvis and hips showed no evidence of fracture, dislocation or bone pathology. Os acetabuli and hip joints appeared normal. X-rays of feet revealed normal bone development with a downward and inward rotation of talus, and negative for other bone pathology.

In view of the neurological findings the patient was referred to a neurologist with a tentative diagnosis of an upper motor neuron lesion on April 21, 1960. On May 27, 1960, the neurologist reported:

> Examination revealed a child of about 1½ years who appeared to be in no discomfort. The child, however, could not be made to stand or walk. As far as we could determine, there was no ataxia in the upper extremities. Funduscopic examination revealed a rather severe, acute papilledema, bilaterally, with multiple small hemorrhages around the optic discs. X-rays of the skull revealed some moderate enlargement of the cranium with widening of the cranial sutures and increased digital markings indicating increased intracranial pressure. It was felt that the child had a cerebellar tumor, probably on the midline. However, she was running a temperature and had recently been exposed to measles. Therefore, it was felt that the operation should be delayed until the acute infection was controlled. The patient was discharged from the hospital until she was over the measles.

This patient was readmitted to the hospital about 10 days later and shortly thereafter, a ventriculogram was done which revealed a moderately severe hydrocephalus with involvement of both lateral ventricles and of the third ventricle. There was also an enlargement of the aqueduct of Sylvius. Immediately following the ventriculogram the patient was operated upon. A suboccipital craniectomy was performed and a large midline cerebellar tumor was encountered. This was a cystic tumor which was approximately 2½ inches in diameter, in-

volving primarily the vermis of the cerebellum in the medial portion of the left cerebellar hemisphere. It was possible to remove the cyst entirely and microscopic examination of the tumor revealed it to be an astrocytoma. Her postoperative course in the hospital was uneventful and she was discharged from the hospital about 2 weeks following surgery. At the time of discharge, she was beginning to stand on her legs and take a few steps. Her papilledema was regressing. It is believed that the patient's tumor has been removed completely, that she is cured and that prognosis for complete recovery of function in the child is excellent.

Although complaints like this do not come into our offices every day, this case reminds us to examine these children very carefully, considering the entire lower extremities.

25862 W. Six Mile Rd.
Detroit, Mich.

Book Review

The Principles and Practice of Chiropody

John F. Hanby, F.Ch.S., Consulting Chiropodist, Guy's Hospital and London Foot Hospital; First President of the Society of Chiropodists, and H. E. Walker, F.Ch.S., Superintendent, London Foot Hospital and Principal of the School of Chiropody; formerly Hon. Chiropodist, Charing Cross Hospital, London. Foreword by Norman C. Lake, M.D., M.S., D.Sc., F.R.C.S.; Hon. Consulting Surgeon, Charing Cross Hospital, author of "The Foot." Price $7.00 pp. 424, Williams and Wilkins Co., Baltimore, Md., exclusive U. S. Agents.

This is the second edition of this book, the first having been published in 1949. This second edition, containing much new material, is a revised and enlarged version of the first.

In all its 33 chapters the authors have endeavored to set forth a clear and concise treatise on chiropody. This starts out with a chapter on the structure of the foot and goes forward in an orderly progression to the functions of the foot in the next chapter, etc., until the topic of Shoe Therapeutics is covered in Chapter 33.

Every chapter is enriched by a copious number of illustrations (151 total) to better explain each important topic that they discuss.

The book might have been much enriched if they had also discussed the surgical aspects as well as the manual aspects of treatment. However, it is an invaluable reference for the student and new practitioner and a useful reference or manual for the practitioner.

The final chapter on "Shoe Therapeutics" is among the best that I have read, and contains much practical information for the practitioner as well as the student.

In summation, the book is a refreshing change of pace from most of our current treatises on the foot and can well take its place among the valuable sources of reference of the practicing podiatrist.

D. L. Norwood

A good leader takes a little more than his share of the blame; a little less than his share of the credit.

Arnold H. Glasgow

JOURNAL
OF THE
AMERICAN PODIATRY
ASSOCIATION

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A. RUBIN, D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

President's Message: "To Better Serve"

THE relationship of any profession, including podiatry-chiropody, to the society that it serves is an ever-changing one. As the society develops and as the profession grows, we must take into account the development of society and the growth of the profession in an effort to be effective and to be able to continue to serve the public to the very best of our talents.

Therefore, it seems to me that the time has come when we must be willing to expose ourselves to the scrutiny of inspection and evaluation, not because we feel that there is anything radically wrong with the profession, but rather we must be desirous of improving ourselves because of our responsibility to our role in society.

This will take much time, effort, talent and money. We must try to enlist the support of outside agencies, such as, possibly, the American Council on Education, the United States Public Health Service and others, to survey and develop a commission of study of podiatry-chiropody, which would include foot health, podiatry-chiropody practice, education and research.

We have had several preliminary surveys which can be incorporated and made useful. I am happy and thrilled to congratulate the Council on Education and our national office for its insight to institute last August the Kuder Testing Key. And now, the establishment of a Special Commission on a Study of Podiatry-Chiropody Education, chaired by Dr. William R. Selden, Executive Director of the National Commission on Accrediting, whose purpose will be the evaluation of our educational institutions with recommendations for improvement.

All of these things are necessary and important. We must take immediate steps toward the development of a National Commission, enlisting the aid of outside agencies and the general public so that we as a profession may "BETTER SERVE."

Federal Employees Health Benefits Program

The two Federal Government-Wide Health Insurance Plans organized under the Federal Employees Health Benefit Act of 1960, now recognize "Certain Podiatrists' Charges for Covered Medical and Surgical Expenses." These two plans cover 1,500,000 out of 1,800,000 Federal employees and their families. Further information on these plans has been distributed in a special Newsletter to members.

The Government-Wide Indemnity Benefits Plans administered by the Aetna Life Insurance Company, for 120 commercial insurance carriers has been modified by "Administrative Liberalization XIX" to provide for recognition of certain claims for our services, especially for treatment in connection with non-occupational injuries and foot surgery within our scope of practice.

The Blue Cross-Blue Shield plan has been expanded to provide for processing of claims for services by podiatrists-chiropodists in all states, including those in which we do not as yet participate.

To assist our members and the two insurance carriers, Assistant Secretary Nyman will serve as consultant with the Group Hospitalization, Inc., for the Blue Cross-Blue Shield Government-Wide Plan and Secretary Rubin, as chief of consultants, for the Aetna Administered Plan.

The remaining 300,000 Federal employees are covered by 14 employer organization plans and 20 comprehensive (panel) medical plans. Several of these latter plans, which service limited geographic areas, include podiatrists on the panel. Negotiations have proceeded to point where more than 75 percent of these 300,000 may elect a podiatrist-chiropodist to perform a provided service.

This is a culmination of several years' effort beginning with (1) contact with members of congressional and senatorial committees and (2) presenting testimony at congressional hearings, followed by (3) discussions with the Director of the Civil Service Commission, Bureau of Retirement and Insurance and members of his Advisory Council, (4) and negotiation and communication with the many health insurance companies and the National Blue Shield office. The effort of many people has gone into this major success, including past and present members of the Board of Trustees and individual members of the state societies contacting their U. S. Senators and Congressmen. The advice, guidance and help of Mr. Leonard Zimmerman of the NAC Agency, Inc., our Insurance Counselor, is especially noteworthy.

These events are but forerunners of greater opportunities for service to our patients. Favorable claim experience by carriers will assist your officers in their endeavors on behalf of your patients.

Pharmaceutical Preparations for the Profession

Harry L. Hoffman, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Caldecort
Dermatologic Ointment

Description: Antifungal, antibacterial, anti-inflammatory and antipruritic. Each gram of Caldecort Ointment contains calcium undecylenate 30 mg. (3%); hydrocortisone acetate, 10 mg. (1%); neomycin sulfate 5 mg. (0.5%) equivalent to 3.5 mg. neomycin base, in a water-washable base. Caldecort is a stable, non-irritating, virtually non-sensitizing preparation.

Indications: Effective therapy for a broad range of allergic, inflammatory and infected skin disorders including atopic dermatitis, contact dermatitis, mycotic dermatoses, impetigo, otitis externa, infected eczematoid dermatitis, pruritus ani and anogenital pruritus.

Advantages: Caldecort combines antifungal, antibacterial, anti-inflammatory and antipruritic action to relieve itching and inflammation promptly and to control bacterial and fungal infection. It is effective where antibiotic preparations alone often fail, because of its active antifungal ingredient, calcium undecylenate.

Dosage and Administration: Apply to affected areas 2 or 3 times daily.

Supply: 7 gm. (¼ av. oz.) collapsible tube. By Maltbie Laboratories, Division of Wallace and Tiernan, Inc., Belleville 9, N. J.

Mysoline®
(Brand of Primidone)
Therapeutic Classification: Anticonvulsant

Description: The new "small" potency Mysoline tablet is designed to facilitate dosage adjustment in therapy of grand mal and psychomotor attacks. It provides 1/5 the potency of the standard Mysoline tablet (0.25 Gm.).

Action and Advantages: The new Mysoline 50 mg. tablet is of particular value, in selected cases, for initiation therapy, especially in children, and where drowsiness is a complication. It is also useful for combination and "transfer" therapy where small upward and downward adjustment of dosage may be necessary. Mysoline 50 mg. is also indicated as additional support in times of stress.

Supply: 50 mg. tablet is available in bottles of 100 and 500. The regular Mysoline tablet 0.25 Gm. (250 mg.) is available in bottles of 100 and 1,000. On prescription only. By Ayerst Laboratories, New York City.

Timovan®
Brand of Prothipendyl Hydrochloride

Therapeutic Classification: Calmative for relief of anxiety and tension in the ambulatory patient.

Description: Timovan is [4-dimethylaminopropyl-pyrido (3.2B) (1,4) benzothiazine] hydrochloride-monohydrate.

Action and Advantages: Timovan alleviates tension and anxiety through its central effect to inhibit overstimulation of the cortical and psychic areas of the brain, without drowsiness or functional impairment even in long-term therapy. It stabilizes the autonomic nervous system by reducing excessive response to irritating stimuli, most useful in treating the neurogenic component that aggravates symptoms of other diseases such as acne, allergies. While nonhypnotic, it is reported to produce improved sleep patterns and is thus preferred to barbiturates where these are not well tolerated or are undesirable because of danger of overdependence. It is nonaddic-

tive, and is remarkably free of side effects; no toxic reactions have been reported. The calmative effect is not diminished on long-term therapy.

Indications: Recommended for the relief of tension in the ambulatory patient, especially the geriatric and adolescent patient; and to treat the neurogenic component aggravating symptoms of other disorders (acne, other dermatoses, allergies, G.I. disturbances, hypertension, menopausal distress, arteriosclerosis).

Dosage: One or two tablets three or four times daily. Depending on age of patient and severity of symptoms, dosages ranging from 100 mg. to 400 mg. daily (in divided doses) have been used effectively.

Precautions: Timovan should not be used in cases of acute alcoholism or barbiturate poisoning.

Supply: Timovan (Brand of Prothipendyl hydrochloride) No. 739—25 mg. tablets in bottles of 100 and 1,000; No. 740—50 mg. tablets, bottles of 100 and 1,000. By Ayerst Laboratories, New York 16, N. Y.

Domoform™ (pH 5.6)

Description: Creme containing 3% iodochlorhydroxyquin in the exclusive Acid Mantle® vehicle. Ointment containing 3% iodochlorhydroxyquin in the exclusive Domolene® ointment base.

Indications: Domoform Creme is indicated in the treatment of infectious or eczematous skin conditions. The exclusive Acid Mantle® vehicle potentiates the antibacterial/antifungal action, restores and maintains the protective acidity of the skin, facilitates healing. Domoform Ointment is designed for the treatment of chronic eczematous dry skin.

Directions: Apply as often as necessary in the treatment of the eczematous skin.

Supply: Creme 1 oz. tube, 1 lb. jar. Ointment 1 oz. tube, 1 lb. jar. By Dome Chemicals Inc., New York 23, N. Y.

Domoform-HC™ (pH 5.6)

Description: Creme or lotion containing 5 mg./Gm. of micronized hydrocortisone alcohol and 3% iodochlorhydroxyquin in the exclusive Acid Mantle® vehicle. This exclusive vehicle potentiates the anti-inflammatory/antibacterial/antifungal actions of the ingredients, restores and maintains the protective acidity of the skin and facilitates healing.

Indications: A wide range of usefulness in a great variety of eczematous and eczematoid eruptions, including infected 'eczemas' in general.

Directions: Apply as directed by physician.

Supply: Creme ½ oz. tube, 1 oz. tube. Lotion ½ oz. bottle. By Dome Chemicals, Inc., New York 23, N. Y.

The leader's duty, ordained by his nature,
Is to be bold, unflinching and fearless,
Subtle of skill and open handed,
Great-hearted in battle,
A resolute ruler.

—*The Song of God*
Bhagavad-Gita

Tax Clinic

Henry Kent, C.P.A.
New York, N. Y.

Mr. Kent will conduct a regular column on tax problems for the podiatrist-chiropodist. Your questions may provide the basis for future columns.

Tax Rules on Exemptions for Dependents

Having just become a father, the tax rules regarding dependency exemptions have a special personal meaning to this writer.

There are three requirements that must be met before you can claim an exemption for a dependent on your tax return. All three tests must be met.

1. The dependent must have less than $600.00 of gross income (except where the dependent is a child under 19 years of age or is a child of any age *and* is a *full-time* student).

2. You must contribute to more than one-half of the dependent's support. An exception to this rule is made in case of shared support of a dependent, which will be discussed below.

3. The dependent must be related to you and/or he must fall within the specified classes of dependents. These classes are as follows: Children, grandchildren, etc.; stepchildren (but not their descendants), brothers, sisters, stepbrothers and stepsisters, half-brothers and half-sisters; parents, grandparents, etc.; stepfathers or stepmothers (but not their parents); nephews and nieces (including adopted children of a brother and sister); uncles and aunts; "in-laws"—son, brother, father, etc.

Furthermore, a person (not necessarily related) who has his principal place of abode in your home during the *entire taxable year,* and is a member of your household, such as an unadopted foster child, but not a common law wife whose residence is not sanctioned by local law, if the other dependency tests are met (support and earnings tests), can be claimed. So, if you have such a possible dependent living with you during the entire year, don't let him move out before December 31st or you will lose the dependency exemption.

A cousin does not qualify as a dependent, unless he is receiving institutional care on account of mental or physical disability, and who, before receiving institutional care, was a member of the same household as the taxpayer.

Legally adopted children are considered children by blood. A child *placed* with a taxpayer for adoption by an authorized agency during the year (as well as a legally adopted child) is also treated as a child of the taxpayer. This permits the taxpayer to claim an exemption for a child *placed* with him for adoption, even though the child was not a member of his household for the entire year. Foster parents do not qualify as "parents" but, if the support and earnings tests are met, then a foster parent is entitled to an exemption for such children who lived in his home and were members of his household for the entire year.

If "the relationship of affinity" is once established, it will not be broken by the death or divorce of the taxpayer's spouse. For instance, the widow of a brother of your wife can be claimed as a dependent on your *joint* return. She could, however, not be claimed as a dependent if you do not file a joint return (since she is legally only a sister-in-law of your wife), regardless of how much you may support the dependent. If your dependent is alive for any part of the year, however brief, and the other tests are met (relationship, support and gross income), the full $600.00 dependency exemption is allowable.

What constitutes gross income as it applies to one of the tests of dependency exemption? It means gross income before

any expenses. For instance, your father, whom you support, owns a house on which he collects $70.00 per month rent or $840.00 per year. Although his business deductions on this rental income for interest expenses, taxes, maintenance, depreciation, etc., may amount to $800.00, leaving him a net income of $40.00, you cannot claim your father since his "gross income" is more than $600.00. If, in another example, your dependent brother sold some stocks he owned for many years realizing a long term capital gain of $600.00, ordinarily (since it is a long term gain) only one-half of the $600.00 is taxable, however, you cannot claim your brother as a dependent. He had $600.00 of "statutory gross income." In determining whether your dependent had gross income of $600.00 or more income which is excludable, such as Social Security Benefits, disability compensation, tax-free interests, exempt compensation of servicemen, etc., is *not* counted. Excludable income is counted in determining whether you furnished over half of the dependent's support.

A taxpayer's child under 19 or a child of any age if he is a *full-time* student does not require the $600.00 earnings test. You are entitled to an exemption (if you support the child) regardless of his income. The child can also take his own exemption when he files his income tax return on his own income. If your child is married and a student, he cannot file a joint return if you claim him as a dependent.

What is support? Support is figured as actual expenses incurred for such items as actual cash contributions, board, lodging, clothing, school tuitions, medical expenses, motion picture shows and other entertainment, transportation expenses, etc.

The taxpayer must provide more than 50% of the dependent support. If your dependent has any income, regardless of whether taxable or non-taxable income, regardless of the source, i.e., social security benefits, it must be figured in determining whether you supplied more than 50% of the dependent's support. But, where the dependent does have an independent source of funds, it is only the actual amount *actually spent* by him on his support which is considered, not the total amount available.

Many "dependents" are supported by more than one person and no one contributes more than one-half of their support. If you would otherwise qualify to claim an individual as a dependent (relationship test and earnings) and you contributed more than 10% of the support of that individual, you may claim a dependency exemption if—1) no one person contributed more than 50% of the support, 2) over half of the support of the dependent was received from persons, each of whom could have claimed a dependency exemption if it had not been for the fact that he did not contribute more than 50% of the support himself, and 3) each person who contributed more than 10% of the support furnishes you with a written declaration on Form 2120, the Multiple Support Agreement, on which he waives his claim for the exemption for the taxable year in your favor. This form should then be filed with your tax return on which you claim the exemption. The support contributors can take turns in claiming the deduction in different years. For instance, five sons contribute about 12% each of their dependent father's support, an unrelated friend about 20% and Social Security another 20% during 1960. The five sons contributed together 60% of the support (more than one-half). Since each of the sons contributed more than 10% of the support, one of them could claim the dependency exemption for the father if the others agree to furnish and sign the Multiple Support Agreement to the one who claims the exemption. Next year, if similar conditions prevail, another son could claim the exemption.

In another article, I will discuss tax situations arising out of divorce and deductions for medical expenses for dependents.

to Manchester, England, where I addressed The Society of Chiropodists at Hope Hospital. Miss D. Grant Nisbet, M.Ch.S., was chairman of this meeting. Mr. John R. Hall and Mr. Franklin Charlesworth were my gracious hosts. It was my privilege and pleasure to be the house guest of Mr. and Mrs. Charlesworth of Cheetham Hill Road. Mr. Charlesworth accompanied me by train September 30th to Edinburgh, Scotland, where we were met by Mr. Donald Neale, Superintendent of Edinburgh Foot Clinic and School of Chiropody. Mr. Charlesworth and I presented a program to The Society of Edinburgh, October 1st, at the School of Chiropody. My subject was "The Management of Forefoot Problems and The Uses of the Injectables." Mr. Charlesworth's subject was "New Developments in the Field of Orthopedic Appliances."

I found a great deal of interest being expressed by British Chiropodists in our International Meeting to be held in Washington, D. C., in 1962 in connection with our 50th anniversary. They want to know more about our American way of chiropody, our educational set-up and our methods of practice. One of their problems is the limited amount of funds they are permitted to take out of Great Britain. I assured them that they would be most welcome in America and we would extend them every courtesy and help in any way possible to make their visit more pleasant and educational.

Columbus, Ohio

Podiatry-Chiropody Abstract

Jerome Shapiro, Pod.D.
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Editors of Local, State and Regional Publications are requested to provide copies to Dr. Shapiro who is editing this section of the Journal.

Some Factors Affecting Growing Feet

C. H. Barnett, M.B., F.R.C.S., The Chiropodist, Vol. 14, No. 10, Oct. 1959.

In this lecture presented to the London Branch of the Society of Chiropodists, a well-known anatomist debunks old theories pertaining to arch and forefoot problems and advances new ones which are based upon statistical surveys conducted by the author.

The author makes some interesting observations on pronation. A true pronated foot with its medial side depressed has a concomitant elevation of the lateral portion of the foot. A school survey points out that up to the age of four, pronation is high. Then it falls sharply and rises again at about 10 years of age. After this it declines again but never disappears, and 6 to 7% of the adult population have pronated feet. The first peak in the two to four age bracket is explained by muscle weakness. A more interesting explanation is afforded by the rise again in the early adolescent group. This is blamed on the fact that the line of the leg is not in the same vertical line as the weight-bearing heel, producing a potential instability. The author has measured this displacement in non-pronated feet and found it greatest in the 10-12 age bracket. Therefore, at this age, there is greater instability and a greater tendency towards the development of pronation. He feels that arch raises or heel build-ups are not enough, for the foot may still fall over medialwards unless the heel seat itself is built up to act as a splint. The undersurface of the heel seat should be flat to prevent rolling in of the foot.

Included in the lecture is a discussion on Morton's theory of first metatarsal with more light thrown on the subject. Interesting observations are made on incidence and cause of hallux valgus and the sock is blamed as much as the shoe as a deforming factor of children's feet.

News of the Profession in Great Britain

Franklin Charlesworth, Ed.D., D.S.C., F.Ch.S.
Manchester, England

A regular series of "letters" about the profession in Great Britain, by Mr. Charlesworth, Editor of the British Chiropody Journal, or arranged for by him, will appear in this column.

The Professional Status of Chiropody in Great Britain

John H. Hanby, F.Ch.S.*

On October 27, 1960, the Royal Assent was given to a Parliamentary Bill known as the Profession's Supplementary to Medicine Bill. This is a landmark in the history of the profession of chiropody. With six other professions, they will have the right to be called "State Registered" and this is the end of a struggle for State recognition which has lasted for 40 years.

It was in 1912 that the late Mr. E. G. V. Runting and Dr. A. W. Oxford first started to organize British chiropody on a professional and scientific basis. From those very early days, three fundamental principles have guided succeeding leaders of the profession. In the first place there has always been close cooperation with the medical profession; secondly, a high degree of scientific education in the training of students entering the profession and thirdly, a strict ethical code. These have been the solid foundations upon which our present structure has been built and which has stood the impact of two world wars.

With the passage through the Houses of Parliament of the Professions Supplementary to Medicine Bill, we are entering a new era which will open up greater opportunities for the younger generation, which will enable them to contribute more to the well-being and general health of the community. Specialization in medical matters has become so advanced that no longer is it possible for one person to be responsible for the treatment of the whole of the human body. Teamwork is now essential. In this specialization, foot problems have assumed major importance. We, therefore, must ensure that our contribution will keep in step with the general advance in the medical world. Too long have we, as a profession, been content with giving temporary relief from pain. Although this part of our work is important, the emphasis for the future must be upon prevention.

What will be the opportunities in the future for a wider application of our work? Our development will be under the guidance of the Council (the coordinating and supervisory body) in the new Bill. It will be responsible for the education, training and examinations in the whole country. More and more chiropodists will be required in the hospitals. In these institutions opportunities are available for associating with other workers in different medical departments. It is significant that, at the present time, only about 15 percent of hospitals have chiropodists holding appointments on their staffs. In the preventive sphere of foot health education and in the regular foot inspection among children there is plenty of room for improvement. Greater cooperation with school authorities is imperative. We must, as a profession, demonstrate to those who are responsible for policy in health matters, by means of lectures and scientific articles, that we have something to contribute to the foot health of children and to the prevention of many deformities which are so common today.

The new Bill enables us to be assisted by representatives of the Royal College of Physicians and Surgeons both in England and Scotland, Medical Officers of Health, general medical practitioners as well as

* First President, The Society of Chiropodists; Consulting Chiropodist, Guy's Hospital and The London Foot Hospital.

professional educationalists. In addition the whole of the structure will be under the guidance of the Privy Council who will appoint the Chairman of the coordinating Council. In this country, the Privy Council enjoys the highest possible status.

There are, however, many other important matters relating to the new Bill. All those who become registered will be subject to an ethical code which will be enforced and administered by two committees. Nobody, except chiropodists on the Register, will be allowed to call themselves "State Registered Chiropodists." Only those admitted to the Register will be qualified for employment in National Health Service Hospitals or by Local Health Authorities. At last the general public will have lists available of practicing chiropodists who have been recognized by the State Boards as being fully competent to deal with chiropodial conditions. For many years to come the largest amount of treatment will still be undertaken by private practitioners. It is therefore essential that the State Boards should ensure that the chiropodists admitted to the first Register should be competent. This will be essential in order to protect the public from the dangers of poor treatment.

There remains much work to be done in compiling the first Register. This will require wisdom and tolerance from those charged with the responsibility of preparing this Register. It will contain the names of practitioners with varying degrees of training and practical experience. Those wishing to be registered at a later date will have to pass through a training school and be successful in examinations approved by the State Board.

The highest attainment of recognition that can be achieved in this country has now been accorded to our profession. It remains for the rising generation to advance further along the road which was started 40 years ago.

Chiropody in Great Britain

H. L. Collins, D.S.C.

My first impression of chiropody in Great Britain was through my contact with Mr. Franklin Charlesworth of Manchester, England. It was my privilege and pleasure to meet Mr. Charlesworth at the Region 3 meeting, in Atlantic City in the spring of 1958 where he was a guest lecturer, and again when he visited America this past May and June, 1960.

I left America via Jet September the 10th, put down at Shannon Airport, and landed at London Airport at 11:00 A.M. on September 11th where I was met by a member of The Society of Chiropodists. At my hotel, cordial messages awaited me from Mr. John R. Hall, President of The Society of Chiropodists, 8 Wimpole Street, London W 1. I visited their offices on September 12th and was most cordially received by Mr. Hall and Major L. W. Griffiths, Secretary of The Society of Chiropodists. It was a most interesting experience to learn of the history and founding of this Society which dates back to 1919. Four delightful days of sightseeing and visitations to two of the principal schools followed; the Chelsea School of Chiropody, under the direction of Mr. P. J. Read, and the London Foot Hospital under Mr. H. E. Walker. Mr. Read was my host at a Rotary Luncheon on September 13th in Crosby Hall.

On September 14th, I was the guest of Mr. H. E. Walker of the London Foot Hospital, 33 Fitzroy Square, in an old and most interesting section of London. One of the classrooms of this hospital was once occupied by Whistler, the famous painter, and from the front window could be seen the apartment where George Bernard Shaw wrote some of his famous plays. Mr. Walker, of the London Foot Hospital, took me on a tour through his clinical buildings, classrooms and laboratories.

It was interesting to learn that approximately 60 percent of the chiropodists in England are women. Their course of study consists of 3 years. While limited in practice by their laws to the general treatment of excrescences, I found them most adept and skilful in their operations. In private practice their offices are called surgeries and the average fee is one guinea or 21 shillings, which is the equivalent of approximately $3.00 in American currency. Under the National Health Program, chiropodists are paid approximately 10 shillings,. or $1.40 per patient. Much of this type of service is rendered in clinics or outpatient departments of the hospitals. There are two programs in this type of service: one is under the Department of Education and the other is under the Department of Health. Excellent provisions are made by these departments to aid students financially to become chiropodists. They start as early as the age of 17. England is still faced with the problem of the unlicensed, the correspondence school type of practitioner and the chiropodist with little or no formal training, who are not recognized by The Society of Chiropodists. There are approximately 9,000 chiropodists practicing in the British Isles. Organized chiropody as represented by The Society of Chiropodists is striving for better recognition and for a broader scope of practice, such as local anesthesia, minor surgery and injectables.

I traveled by English car to Norwich. Norwich was the scene of the Annual Convention of The Society of Chiropodists which met on September 15, 16, 17, at Stuart Hall, Suckling House, St. Andrews Street, Norwich. The reception and formal banquet was at the Sampson and Hercules House, Tombland, Norwich. The formal banquet was most interesting and a delightful occasion. A reception was given by The Right Worshipful Lord Mayor of Norwich Alderman, A. E. Nichols, who extended a most cordial welcome to the visiting chiropodists and their wives. Approximately 150 chiropodists were in attendance at this convention which was held in Stuart Hall. Lectures and papers were given by well-known orthopedic surgeons, such as Mr. G. K. McKee, F.R.C.S., Mr. R. C. Howard, F.R.C.S., Mr. J. P. Stephens, F.R.C.S., and Mr. J. G. Taylor, F.R.C.S. These men also conducted general operating sessions at the local hospitals where the members of The Society of Chiropodists were invited to observe. Most of the surgery that I witnessed was of the knee, hip and spine. I did not observe any surgery of the lower feet. There were other medical men on the program such as plastic surgeons, dermatologists and psychiatrists. I addressed The Society on September 17th on "The American Way of Chiropody." One other member of the chiropody profession, Mr. H. Rosenstein, F.Ch.S., presented a paper on "The Chiropodial Management of the Pre-Gangrenous Foot." Visits to five leading shoe factories and an afternoon boat trip of the Norfolk Broads concluded the convention. On my return trip from Norwich to London, I visited Kings College in Cambridge, England, noted for its splendid departments of law and medicine.

I flew from London to Dublin, Ireland, on September 18th. Here, press interviews attended by eight reporters and three photographers from four of Ireland's leading newspapers had been arranged. Their main interest was the effects and results of needle pointed shoes, or as they call them, "winkle pickers." I had made statements on these shoes in Norwich where the English Press and BBC Television had interviewed me. Norwich, the shoe capital of England, was very much interested in what a chiropodist thought of the correct type of footwear. My suggestion was that a woman's wardrobe should consist of four basic types of footgear: a low heel oxford tie for morning wear; a dressier medium heel for luncheon and afternoon wear; a slightly higher heel, dressier type shoe for the tea or cocktail hour and high heel pointed toe shoe for strictly evening wear. Chiropody in Ireland is not too well known. I visited the offices of Mr. Cahill in Dublin and found it to be busy and well kept.

On September 27th, I flew from Dublin

Digests From The Literature

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

Musculoskeletal Disorders

Histologic Changes in Subcutaneous Rupture of the Achilles Tendon: A Study of 74 Cases, Arner, O., Lindholm, A., and Grell, S. R. Acta chir. scand. 116: 484-90. 1958-59.

This injury is most common in men, usually less than 40 years of age. Most of these patients have indulged in some form of athletics. The rupture generally occurs during a period of inactivity. In a study of 74 cases of subcutaneous rupture of the free part of the Achilles tendon, this was the first rupture except in three patients who had been treated earlier, but a second rupture occurred in 2½ to 3 months. However, degenerative lesions were found in all 74 cases, even in 12 patients in whom repair was done on the same day of the rupture. This indicates that regressive changes in tendon tissue are prerequisite for such rupture.

Four different stages of healing were distinguished. (1) When the operation is performed within 24 hours of the rupture, it is characterized histologically by inflammatory cellular infiltration into the tendon; no granulation tissue is present. (2) When the operation is performed after 1 to 4 days, fairly profuse infiltration of leukocytes into the tendon tissue is noted, but no granulation tissue is seen. (3) If the operation is performed from 3 to 4 days to about 2 weeks after rupture, more or less granulation exists, but the inflammation is subsiding. (4) Finally the tissue is largely replaced by newly formed undifferentiated connective tissue.

These inflammatory and regenerative changes are secondary to hemorrhage and tissue damage connected with the rupture. The degenerative changes seen in the beginning are not secondary to traumatic tissue damage and are entirely unrelated to secondary changes following the rupture.

The cause of the degenerative changes which occur prior to rupture remains unknown. It is assumed that the cause is impairment of the blood supply.

Vascular Distribution in the Achilles Tendon: An Angiographic and Microangiographic Study, Lagergren, C., and Lindholm, A. Acta chir. scand. 116: 491-95, 1958-59.

Studies were made of the distribution of arteries in the Achilles tendon in 11 freshly amputated legs. The cause of the amputations was malignant tumor in 6, traumatic injuries in 4, and arthritis of the knee joint in one. Ages ranged from 12 to 74 years. Histologic examination showed satisfactory filling of the contrast medium in 8 of the 11 specimens. All 11 legs were examined with conventional angiography; 9 were examined with microangiographic technic.

The findings suggested that the nutrition of the Achilles tendon is poorest in the segment most commonly ruptured. It is believed, therefore, that poor blood supply of that segment makes it susceptible to rupture.

Roentgen Changes in Subcutaneous Rupture of the Achilles Tendon, Arner, O., Lindholm, A., and Lindvall, N. Acta chir. scand. 116: 496-500, 1958-59.

Roentgenologic studies were made of 39 patients with ruptured tendo achillis. Only four were females. The rupture was verified at operation in 37 patients, and in the other two, the rupture was clinically evident. The studies were made in a period of a few hours after the rupture to 4½

months afterward. In every patient Kager's triangle was found to be changed in size, configuration, and soft tissue structure. Toygar's sign (an angle of less than 150 degrees) was positive in two cases. In every case the posterior tendon contour curved away from the calcaneus between the insertion of the tendon and the upper margin of the bone, with the contour remaining more or less distinct.

This curving away from the calcaneus seems pathognomonic of this rupture, combined with an unimpaired contour, and forward deviation of the anterior tendon contour proximal to the calcaneus. The actual site of the rupture was seen in only 14 patients, but these ruptures always involve a limited segment of the tendon, between 2 and 6 cm. above its insertion on the calcaneus.

Avulsion Fracture of the Os Calcaneus, Arner, O., and Lindholm, A. Acta chirscand. 117: 256-60, 1959.

Earlier studies showed that in cases of subcutaneous rupture of the Achilles tendon, invariably degenerative changes can be identified in the tendon tissue, even though the operation was performed within 24 hours of injury. Also, that most of such patients have indulged intensively in some type of sport which caused strain on the Achilles tendon. Tearing away the attachment of this tendon to the os calcaneus, causing avulsion fracture, seems to be due to the same causal mechanism as subcutaneous rupture of the Achilles tendon. Although junction with the calcaneus is the weakest point in the system of muscle, tendon and attachment, avulsion of the Achilles tendon is rare.

Three cases are described in which histologic examination was made of biopsy specimens of the tendon tissue taken at the time of repair. These cases represent the three types of casual violence noted in the series of Achilles total tendon rupture noted earlier: (1) Pushing away of the weight-bearing forefoot and simultaneous extension of the knee joint; (2) sudden, unexpected dorsiflexion of the foot joint; (3) dorsiflexion violence against the maximally plantar-flexed foot. Roentgenologic features were uniform in the three cases. A small part of the tendon was ruptured and the remainder was intact and so tenacious that the trauma caused avulsion of the attachment of the tendon. The same degenerative changes were demonstrated as in rupture of the Achilles tendon tissue. However, none of these patients had indulged in extensive athletics before the trauma. The conclusion remains that degenerative changes in the Achilles tendon are prerequisite, and that a normal Achilles tendon cannot be ruptured by an indirect injury.

Onychology

Observations on Growth of Fingernails in Health and Disease, Sibinga, M. S. Pediatrics 24: 225-33, 1959.

Nails grow at different rates among individuals, but growth rate of any particular nail is relatively constant throughout life. Even uncut, as in Indian ascetics, they continue to grow, curling into the palm. Pregnancy is said to increase growth of nails 25 to 30 per cent, while paralysis, immobilization of a limb, chronic disease and malnutrition are said to retard their growth. In the present study growth was unaffected by menstruation, and not retarded in infants in whose diet essential amino acids were omitted.

Growth of the fingernails in 37 human subjects was measured by use of photographic technic at intervals of 3 to 4 days over a period of 3 months. The average growth for males was .108 mm. per day, for females .104 mm. Over a period from 13 to 50 days, nail growth was measured in 13 premature infants weighing at birth 1,150 to 1,900 gm., and the rate of growth found to be of the same general range as for full term infants and adults.

Nail biters are said to have increased growth of nails. One child hospitalized for rheumatic heart disease—a prodigious nail biter—showed variations in nail growth

over a 53-day period, but within normal range. Infectious diseases had no effect on growth of nails with the exception of measles and nephrosis which arrested growth for 2 to 7 days. Transverse ridges may develop as a result of brief arrest of growth, and also may be induced by hypoalbuminemic states. Patients with rheumatoid arthritis have a reduced content of cystine in the nails but not delayed growth. In 3 of 14 newborns formation of transverse ridges was noted, suggesting that lag in nail growth in early days is an inconsistent phenomenon.

Post-mortem studies showed continued growth of the nails for the first 2 or 3 days, within low normal range of live subjects, then slower afterward, but growth had not ceased when the study was discontinued on the tenth day.

Shoes

Shoes and Feet (Editorial). Brit. Med. J. 1: 488-89, 1960.

The various studies which have been made regarding the relationship of shoes to deformities and other conditions of the feet have shown there is still room for honest divergence of opinion. The claim that there would be no foot ailments if footwear were suitable (except for congenital disease and gross injury) can hardly be accepted, since valgus deviations are found in Africans and Chinese who have never worn shoes. Some writers believe that many of the common foot disorders are partly determined by inherent weaknesses in the foot itself, combined with restrictions of foot movements imposed by civilized life.

A number of surveys have been made of the feet of school children in London, Birmingham, and recently in Stirlingshire. The observers agree in certain points, although the criteria of abnormality are not always uniform. Hallux valgus occurs more often in girls than in boys (aged 5 to 15 years), the disproportionate increase in girls starting at about the age of 9. Lake's early theory was that the cause of this is the wearing of high heels. The Sterlingshire survey (1959) attributed the disorder to wearing "casual shoes" (probably referring to low-heeled shoes with soft uppers), and to wearing footwear that was too small. Yet this survey revealed that of the children who wore unsatisfactory shoes at the age of 16, only 94 had some foot defect, whereas 115 had no defect. All studies indicated the need for footwear of proper size to allow for growth and for extension of the toes. One of the early studies (1939) showed that shoes are frequently bought for children without being tried on or fitted; yet in only 10 of 1,024 cases of foot disorders was referral to an orthopedist considered necessary, and only 2 of the 10 were found to need treatment.

Recently the Parliamentary Secretary to the Ministry of Health announced that a privately financed independent survey of children's feet at various ages would be undertaken as a "research project."

Rheumatic Diseases

Treatment of Acute Gout with Injection of Colchicine, Carmichael, L. P. J.A.M.A. 170: 1410-11, 1959.

Colchicine remains the most useful drug in treatment of gout. However, given orally, it frequently causes nausea, vomiting and diarrhea. When given intravenously, in specific doses, gastrointestinal side effects rarely occur, and the response is more rapid. Intravenous colchicine is also of value as a diagnostic procedure. In the four cases described, the patients received initially 2 mg. (4 cc.) intravenously, either in the hospital or in a doctor's office; then 1 mg. within 12 hours or 2 mg. on the next day, and then they were given colchicine and probenecid orally for about 2 weeks, (except one patient who received maintenance oral doses up to the time he died several weeks later of myocardial infarction). None of the patients suffered gastrointestinal side effects; one patient had a mild thrombophlebitis which subsided rapidly.

Organization News

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

California
Southern Division

A series of five weekend conferences are planned by the Southern Division of the California Podiatry Association. The program has been planned as a West Coast Conference series on Advanced Practice Methods in Podiatry with emphasis on knowledge and information that can be applied to everyday practice. The first meeting will be held February 11 and 12 at the Hollywood Roosevelt Hotel. Dr. William Bowdler will present "Doctor-Patient Relations, Practice Administration and Office Management." In the second session on March 17, 18, 19, Dr. Marvin Steinberg will conduct a 3-day session on "How to Broaden Your Podiatry Practice," a consideration of advanced diagnostic and treatment methods. "Complications of Foot Surgery" will be presented April 15 and 16 by Dr. Henri L. DuVries and John Collet.

Dr. Harry Lawson of Seattle, Washington, will present the fourth program, "Dynamic Muscular Relaxation," May 13 and 14. The fifth program, date and place to be announced later, will be presented by Dr. Robert G. Addison.

Iowa

At the semi-annual business meeting of the Iowa State Chiropody Association, held December 3, 4 in Cedar Rapids, Iowa, the following officers were elected: President, R. E. Holdeman of Cedar Rapids; President-Elect, James W. Moore of Cherokee; First Vice President, Raymond S. Wilson of Atlantic; Second Vice President, Paul A. Johns of Des Moines, and Secretary-Treasurer, C. L. Watts of Des Moines.

Dr. Joy Adams was the principal speaker of the scientific sessions. A testimonial banquet was held in honor of Dr. Marr, President of the A.P.A.

"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Podiatrists-Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

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New York

The National Baby Care Council in cooperation with the Podiatry Society of the State of New York, has prepared and released a foot care story for distribution to all weekly newspapers in the United States.

The article entitled, "Give Baby a Sound Footing," carries the by-line of Dr. Milton Werbel, President of the New York Podiatry Society. The point is made that American children, although the best cared for in the world, receive little or no foot care. The surveys made by the Podiatry Society are stressed and parents are urged to have feet checked just as routinely as other parts of the body. Pick-ups on the story have already been reported from the west coast and midwest and it is expected that several hundred weekly newspapers will carry this foot care story.

Pennsylvania

Berks County

The Berks County Chiropody society held its annual banquet and dance at the Berkshire Country Club, Reading, Pa., on November 19, 1960. Toastmaster was S. P. Toth, D.S.C., and Guest Speaker for the occasion, Elmer Harford, D.S.C., Professor of Anatomy at Temple University School of Chiropody, spoke on "Medical Hypnosis."

Drs. Bartos, Geist and Copazello served as members of the banquet committee.

During the month of November, the Berks County Chiropody Society participated in the annual Diabetes Fair, sponsored by the Berks County Medical Society. Members Pace, Toth, Miller, Drezner and Copazello participated in an interesting panel discussion on diabetes. Following the panel discussion there was an interesting and lengthy audience participation session in the form of questions and answers.

North Central Division

At a meeting of the North Central Division on December 6, 1960, at the Lycoming Hotel in Williamsport, Pa., the following new officers were elected: President, Richard G. Stuemfle of Lock Haven; Vice Presi-

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II. How to Broaden Your Podiatry Practice—Marvin Steinberg, Pod.D. March 17, 18, 19. Fee $50.00

III. Complications of Foot Surgery—Henri L. DuVries, D.S.C., M.D.; and John Collet, D.S.C. April 15, 16. Fee $30.00

IV. Dynamic Muscular Relaxation—Harry Lawson, D.S.C. May 13, 14. Fee $35.00

V. Medical and Surgical Approaches to Orthopedic Problems—Robert G. Addison, M.D. Date and place to be announced. Fee $20.00

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For full details and outlines of each week-end program, write: Dr. Anthony DeLeo, California Podiatry Association, Southern Division, 1630 North Edgemont, Los Angeles 27, California.

Presented by the California Podiatry Association, Southern Division

dent, Sidney C. Sivitz of Lewiston; Secretary-Treasurer, James H. Spotts of Williamsport; Division Council, Harold S. Kaiser of State College, John N. Startzel of Shamokin and Eugene Egan of Williamsport.

Rhode Island

At the regular monthly November meeting of the Rhode Island Podiatry Society held at the Sheraton Biltmore Hotel, Attorney George Roche, Chairman, Workmen's Compensation Board, discussed the problems connected with accidental injuries incurred during employment and their effect on the podiatrists of the state. There was a question and answer program immediately following his address to clarify the issues involved. The regular business meeting of the month was conducted for the remainder of the evening.

R. I. Diabetic Fair Committee

Dr. Leonard H. Lerner of Warwick, and Dr. Michael Romano of Barrington, R. I., were recently appointed co-chairman of the

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Diabetic Fair Committee of the Rhode Island Podiatry Society.

Three Diabetic Fair Programs were scheduled for the week of November 13th through the 22nd, 1960, which were open to the public and in which the Rhode Island Podiatry Society participated. These Diabetic Fairs were part of a nationwide detection drive to find the estimated one million Americans who have the disease but who do not know it. The programs were conducted under the auspices of the Rhode Island Department of Health and were held as follows: November 16, 1960, Pawtucket Memorial Hospital, Wednesday, 10:00 A.M. to 9:00 P.M.; Army Reserve Training Center, Sandy Lane Road, Warwick, Sunday, November 20th, 10:00 A.M. to 9:00 P.M.

A large, illuminated exhibit entitled "Foot Disorders Associated with Diabetes Mellitus" was displayed and literature of an instructive and informative nature was distributed by doctors of podiatry who are members of the state and national podiatry associations.

Texas

Chartered since 1931, the Chiropody Society of Texas, Inc., established its first permanent state headquarters office on November 1, 1960, in Austin, the Capital City of Texas. Society officers chose the Austin Savings Building, located near the State Capitol, and installed a modern suite of offices, staffed and equipped to serve the chiropody profession. The Executive Secretary of the Texas Pharmaceutical Association, Mr. C. J. M. Roesch, will also direct

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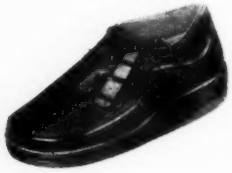

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the affairs of the new state office for the society and is giving his services on a voluntary basis.

C. J. M. Roesch is a native Texan, born in Dallas, where he attended Southern Methodist University, receiving a B.S. degree in Personnel and Business Administration.

In making the announcement, the Society President, Ben L. Smith, Jr., of Dallas, said, "This forward step of our profession, in providing its members with a central headquarters office, has been long sought by leaders for years. We realize how much better organization will accrue to our Society, if the activities are directed and planned by a professional association executive. While the office will not replace the functioning of committees of chiropodists, assigned to various projects, it will afford them additional assistance and better integration of their duties, within the overall framework of the policies of the Society prescribed by the officers and members." Mr. Roesch is a 12-year veteran in the field of professional association management.

President Smith called the first meeting of society officers and the Board of Governors in Austin for December 17 to establish certain policies relating to the operations of the new state office. On the following day, 1960-61 committee chairmen conferred with society officers to plan the activities of their respective committees for the ensuing year.

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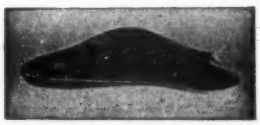

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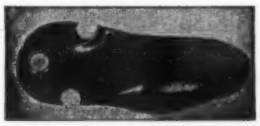

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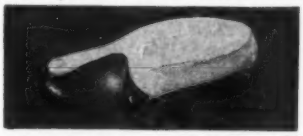

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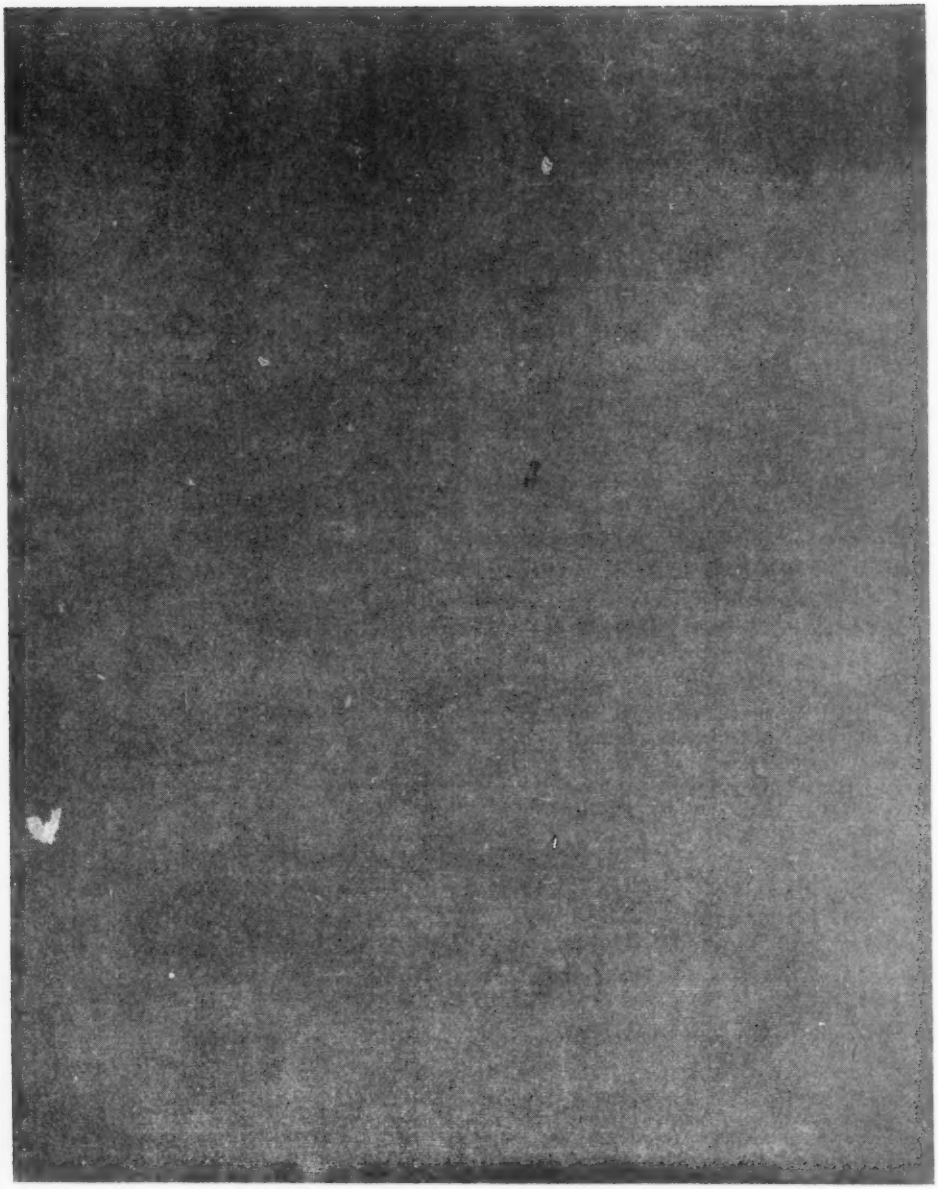

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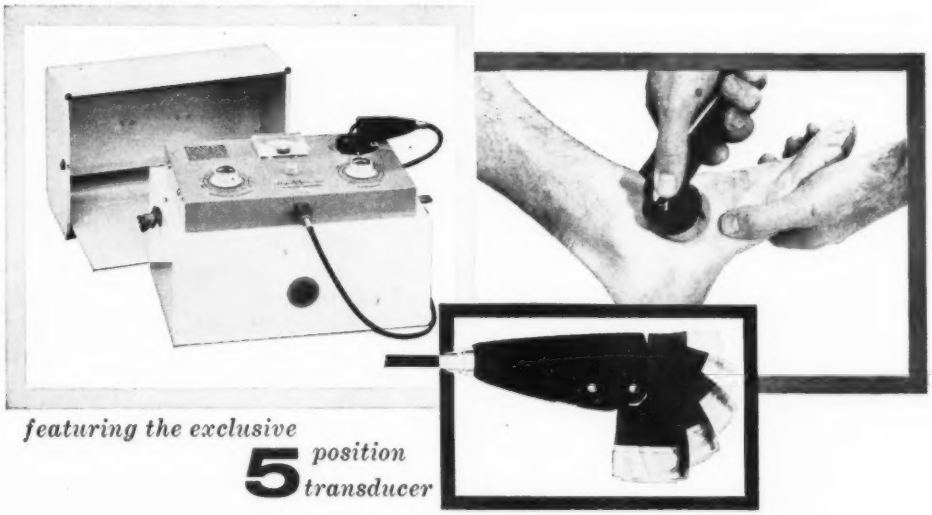

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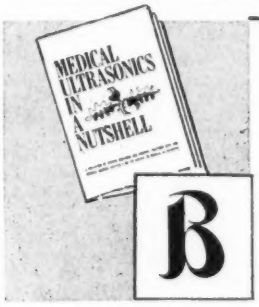

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City _____ Zone ____ State _____

Women's Auxiliary Message

As we enter the new year, I would like to share with you the following thoughts which were written by Atty. Gerald B. Klein of Tulsa, Oklahoma.

Today and Happiness

Today I must remember that happiness is not in having or being, it is in doing. The greatest happiness comes from service to others.

Today I must remember that the happiest person is the one who thinks the kindest thoughts. Happiness and health go together. Health is largely a condition of mind.

Today I must remember that the opportunity for happiness is given to all. Happiness is fickle. Power, poverty and wealth have all failed to bring happiness.

Today I must remember that happiness is not to be found at any one place, but yet it is everywhere. Happiness is within us —do not travel to find it.

Today I must remember that the ability to acquire and retain happiness is the ambition of all men. You do not find it, you make it. Accomplishments create happiness.

Today I must remember that the busy person is often the happiest person. It may help you to be happy if you forget yourself and think of others.

Today I must remember that if I am to possess happiness, I must enjoy living now —not for some fictional future time or place.

Today I must remember that the Constitution of the United States guarantees only the pursuit of happiness—not happiness itself. I, therefore, resolve to pursue happiness.

Mrs. Cleotha Parham, President

The Women's Board of the Ohio College of Chiropody

The Women's Board of the Ohio College of Chiropody is an organization composed of the wives of students in the college. The prime purpose of this group is to promote the interest and welfare of the college and the Cleveland Foot Clinic and to maintain good public relations.

One of the activities of the organization is to arrange lectures by prominent local doctors to inform the wives of their role in their husbands' profession.

Last year, the group initiated an anatomy film library fund which will continue to support and supply the school with more adequate films.

During National Foot Health Week of 1960, they contributed their services.

Each year they raise money through raffles and affairs to purchase equipment and to make the surroundings more pleasant for the students. In the past they have equipped the student lounge with a clock and draperies, and have recently donated stainless steel utility tables to the Cleveland Foot Clinic.

The current fund raising project is the sale of the chiropody caduceus in the form of jewelry, available in sterling silver, gold, or gold wash on cuff links, ladies' pins, pendants, lapel pins and tie bars. They also sell charms which can be worn on bracelets or soldered on cigarette lighters. For further information, please write to the Women's Board of the Ohio College of Chiropody, 2057 Cornell Road, Cleveland Ohio.

Legal and Legislative

Illinois

Full participation by podiatrists in Blue Shield-Blue Cross contracts in Illinois following passage of enabling permissive legislation and negotiation has been granted. This will apply to all new "H" and "I" contracts. Policies provide the services of "physicians, dentists and podiatrists." Payment will be made to a podiatrist for any procedure which would be performed in the same case by an M.D. The scheduled fee will be the same for all professions in home, office or hospital.

QUESTIONNAIRE

To insure a continuing program and fulfillment of objectives, it is necessary for the American Podiatry Association to have up-to-date knowledge and records of our members' activities in specific fields.

The questionnaire mailed to you a number of months ago and the results, which appeared in the October issue of this *Journal*, indicated, in general terms, activities in which you are giving your time and services to the public welfare. This follow-up questionnaire will provide us with necessary specific information regarding individuals and institutions.

Please provide the information requested by filling out the blank, or by checking the appropriate category or type. Tear out this questionnaire sheet from the *Journal* and with any supplemental information sheet mail immediately to:

AMERICAN PODIATRY ASSOCIATION, 3301 16th St., N.W., Washington 10, D. C.

Your Name: _____

Address: _____

I. Hospital affiliated with as a podiatrist-chiropodist

Name of Hospital(s) _____

Address of Hospital(s) _____

1. Owned and operated by: (check)

Private parties ☐ State ☐ Fraternal Order ☐
Township ☐ Federal Government ☐ Charitable Order ☐
City ☐ Religious Order ☐

2. Fill in name of sponsoring organization(s) of above:

_____

3. Type of Hospital(s): (check)

General Hospital ☐ Veterans Hospital ☐
Mental Hospital ☐ Other (please identify)

_____

4. Are you associated with treating:

Out-patient only ☐ In-patient only ☐ Both ☐

5. When affiliated: From_____To_____

II. Homes for Aged affiliated with as a podiatrist-chiropodist

Name of Home(s) for Aged: _____

Address of Home(s) for Aged: _____

1. Owned and operated by

Private parties ☐ State ☐ Fraternal Order ☐
Township ☐ Federal Government ☐ Charitable Order ☐
City ☐ Religious order ☐

2. Fill in name of sponsoring organization(s) of above:

_____

3. When affiliated: From_____To_____

III. Nursing Home affiliated with as a podiatrist-chiropodist

Name of Nursing Home(s): _____

Address of Nursing Home(s) _____

1. Owned and operated by

Private parties ☐ State ☐ Fraternal Order ☐
Township ☐ Federal Government ☐ Charitable Order ☐
City ☐ Religious Order ☐

2. Fill in name of sponsoring organization(s) of above

_____

3. When affiliated: From_____To_____

IV. On the teaching staff as a podiatrist-chiropodist

Elementary School ☐ Parochial School ☐ Dental School ☐
High School ☐ Nursery Day School ☐ Osteopathic School ☐
College ☐ Nursing School ☐ Medical School ☐

Other (please identify) _____

1. Name of School(s): _____
2. Address of School(s): _____
3. Years affiliated: From_____To_____

V. Do you have an appointment as a podiatrist-chiropodist with a
Township ☐ State ☐
City ☐ Federal Agency or Department ☐

1. Check those that apply
Education Department ☐ Correction Department ☐
Health Department ☐ Welfare Department ☐
Workmen's Compensation ☐ Navy, Army, Air Force ☐
Hospital Department ☐
Other (please identify) _____
2. Title or status: _____
3. Was this position filled by
Appointment ☐ Civil Service ☐
4. Name of Department: _____
5. Under sponsorship of
Township ☐ City ☐ State ☐ Federal ☐
6. Years affiliated: From_____To_____

* * * * * * * * * * * * * * *

VI. Affiliation with an Industrial Health Service in the capacity of a podiatrist-chiropodist

1. Name of Industrial or commercial firms where you provide professional foot services for employees: _____
_____
2. Address of firm(s): _____
3. Services supplied at: Your office ☐ Hospital ☐
Industrial plant ☐ Other (please identify) _____
4. Years affiliated: From_____To_____

VII. Affiliation with a Labor Union Health Service (s) in the capacity of a podiatrist-chiropodist

1. Name of Labor Union (s) and Local number for which you provide professional foot services for members: _____
2. Address of Union(s) or Local(s): _____
3. Services supplied at
Labor Union Headquarters ☐ Your office ☐
Health Clinic offices of Union ☐ Hospital ☐
Other (please identify) _____
4. Years affiliated: From_____To_____

VIII. Are you affiliated, in a professional capacity, with health or community centers or projects, i.e.,

Cerebral palsy ☐ "Y" work ☐
Rehabilitation ☐ Civil Defense ☐
Cancer ☐ Fraternal Organizations ☐
Arthritis and Rheumatism ☐ Religious Organizations ☐
Research ☐ Parent-Teacher groups ☐
Girl Scouts ☐ Charity Fund drives ☐
Boy Scouts ☐ Local School Boards,
Red Cross ☐ or Board of Trustees ☐

Other (please identify) _____
Name of group(s) you give your services to: _____
Address of group(s): _____
Years of affiliation: From_____To_____
Duties and/or responsibilities: _____
_____
_____

Please fill in supplemental information referring to the specific inquiry by classification and number (use additional sheets if necessary) _____
_____
_____
_____
_____
_____

A Recent Graduate Views Our Student Selection Program

(Editor's Note: What the author states is but a partial solution. Recent studies in medicine and dentistry, which also have student recruitment and selection problems, point out that (1) the schools must become very active in this field, and (2) that the greatest potential source of students is through the practitioner.)

At the end of 4 years of professional instruction and training, I am presenting some of my personal opinions and observations on one problem which is confronting our profession at the school level.

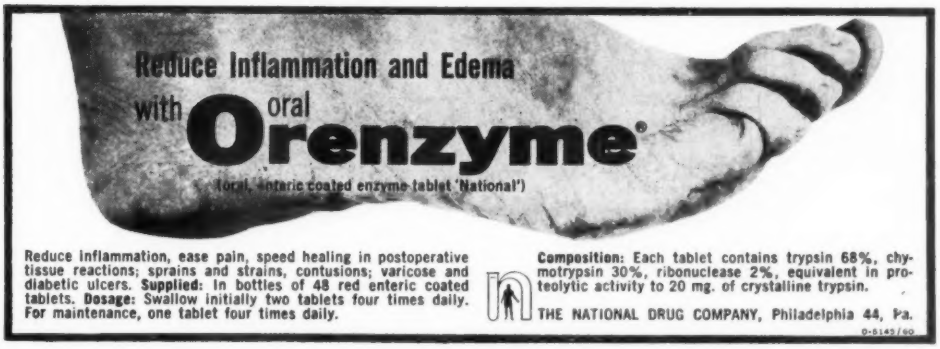
In the past, many ideas have been offered concerning our situation: many of them good, many missing the point entirely. There seems to be a general feeling among practitioners, and especially students, that a problem does actually exist in our schools.

What is this problem and what can be done about it? The two questions raised are: (1) Is the lack of students entering our profession a reflection on our training at the schools, or, (2) Does improper public relations with the potential podiatry student in the pre-professional years at school represent the stumbling block? Most of the graduating students at our particular school felt that faculty public relations in reference to students in the local colleges and universities and even high school seniors is our biggest deterrent to the solution of decreasing student enrollment. Here lies a vast field to be cultivated. We must let students in these schools know about podiatry. They must know its requirements, ramifications and rewards. Every student's advisor must also become informed as to our particular demands.

The majority of students upon entering college have not made definite decisions as to their vocation in life. The first year or two is spent merely feeling their way along reflecting on their abilities and desires. At the time of a final decision as to which field of training to pursue, podiatry is not one of the fields that they debate on. This is due to the simple fact that they are oblivious to its existence and merits.

This lack of students' knowledge concerning podiatry is brought to mind forcibly when I consider my own personal experiences. I graduated from a small private school of 1,200 male students in 1952. After a 3-year period in the U. S. Army I matriculated at a mid-western state university which had an enrollment of 9,000 students. During this time of constant contact with students and people my own age who were planning their future, considering every professional end and possible goal, the field of podiatry-chiropody was not included in their choices: a very distressing situation, to say the least, a result of *no* public relations on the student level.

This conclusion does not mean to infer that continued betterment of our standards of training should stop. During my own 4 years a great many changes took place in respect to better instruction, the addition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of new courses and the demand for better student work, both in didactic and clinical levels. Paradoxically, the student enrollment was declining each year. Many students are being led into the lucrative fields of engineering and electronics. We are slowly losing out because of our failure to present our profession to the right people.

The solution is not simple. We cannot expect the private practitioner to crusade in his particular area, because of the responsibilities of his own practice. Nor do the officials of the individual podiatry schools have the time to contribute.

One alternative that may be possible would be to raise funds for this particular purpose; either on the national or local basis, or any type of combination. Professional public relations people must be engaged to go into the colleges, universities and high schools to place the seeds of our profession into the students' minds, using such facilities as lectures, printed material, library information, films and any other available means.

Again I wish to emphasize that this is only one approach to the problem which I feel the most realistic and one that has been sadly neglected. Continued support of the podiatry schools must continue with the idea of bettering our teaching and training. The Student Public Relations Program is another means to the same end: more students properly trained.

John A. Ritchie, B.A., D.S.C.
Cedar Rapids, Iowa

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Deaths Reported

M. N. Hess
Sault Ste. Marie
Ontario, Canada

J. H. Steiert
Galion, Ohio

Arthur C. Everly
South Bend, Indiana

Dr. Arthur C. Everly of South Bend, Indiana, died in St. Joseph's Hospital October 28, 1960, after an illness of 2 months. A graduate of Illinois College of Chiropody, 1924, he practiced in Chicago for 10 years and became an active member of the Illinois Association of Chiropodists in February, 1926, serving as President for 1 year.

In 1934 Dr. Everly moved to South Bend, Indiana, where he was a member of the Indiana Podiatry Association and served as President in 1948. Upon his retirement he was awarded a life membership.

Dr. Everly was born in Ironton, Ohio, September 5, 1893. He married Gertrude F. Rimmelin in Detroit, August 5, 1918, and enlisted in World War I, serving in the Air Force in France. He was a member of Holy Trinity Lutheran Church, South Bend Lodge 294 AF&AM, Scottish Rite Valley of South Bend, Orak Temple of Hammond, South Bend Shrine Club, South Bend Chapter 2, Order of Eastern Star, serving as Past Patron in 1937 and 1943. He served on the Board of Directors of the Chicago College of Chiropody until June 1959.

Surviving are his wife, a daughter, Mrs. James Parent of South Bend, three brothers, two sisters and two grandchildren.

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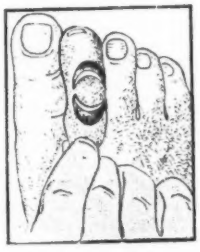

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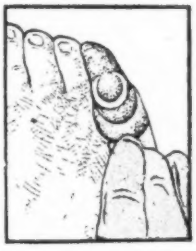
and special types



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EVENTS

Youth Fitness Week

April 30-May 6, 1961. Sponsored by President's Council on Youth Fitness.

Foot Health Week

May 14-20, 1961. Sponsored by American Foot Health Foundation.

Youth Foot Care Week

Oct. 15-21, 1961. Sponsored by American Foot Health Foundation.

MEETINGS

American Podiatry Association

Miami Beach, Fla., Aug. 24-29, 1961
Americana Hotel
Seward P. Nyman, Convention Manager
3301 16th St., N.W., Washington 10, D. C.
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One

(Conn., Maine, Mass., N. H., R. I., Vt.)
Dr. Edward H. Buchbinder
10 Allyn St., Hartford, Conn.

Region Two

(New York)
New York, N. Y., Feb. 24-26, 1961
Barbizon Plaza Hotel
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

Region Three

(Del., Md., N. J., Pa.)
Atlantic City, N. J., Apr. 27-30, 1961
Ambassador Hotel
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

Region Four

(Ohio)
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five

(Ill., Ind., Mich., Wis.)
Chicago, Ill., Mar. 17-19, 1961
Morrison Hotel
Dr. W. D. Canada, Pres.
1812 Nichol Ave.
Anderson, Ind.

Region Six

(Colo., Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Des Moines, Iowa, Apr. 7-9, 1961.
Savery Hotel
Drs. Stewart E. Reed and Ralph C. Kirkwood.
425 Kresge Bldg., Des Moines, Iowa

Region Seven

(Idaho, Mont., Ore., Wash., Wyo.)
Gordon R. Tobin, Convention Chairman
153 Third Ave., North, Twin Falls, Idaho

Region Eight

(D. C., N. C., S. C., Va., W. Va.)
Charles Turchin, Chairman
818-18th St., N.W., Washington, D. C.

Region Nine

(Florida)
Clyde R. Huston, Ex. Sec.
5625 Commerce St., Jacksonville, Fla.

Region Ten

(Ala., Ga., Ky., Miss., Tenn.)
Dr. Paul Lefkoff, Secretary
202 Burdine Bldg., 849 Peachtree St., N.E.,
Atlanta, Ga.

Region Eleven

(Ark., La., N. Mex., Okla., Texas)
Fort Worth, Texas, June 14-17, 1961
Hotel Texas
16th Southwestern Chiropody Congress
44th Annual Convention of Texas Society
Dr. Joseph R. Ordile, 111 Professional Bldg.,
Ft. Worth 4, Tex.

Region Twelve

(Ariz., Cal., Nev., Utah)
Dr. Alfred G. Roos
209 Post St., #412, San Francisco 8, Calif.

International Union of Podology

Second International Congress.
Belgium, France, W. Germany, Holland, Spain, Switzerland, Argentina, Sept. 8-12, 1961.

Mood Elevators

Contributions to this column are more than welcome. In fact it depends upon them. A.O.P.

Patients' Reactions to Name Changes in Podiatry

(Submitted by Dr. Arnold Pock, Lake Forest, Ill.)

1. Doctor, does this change mean you will have to raise your office fees?
2. Doctor, will you mind if I still call you a chiropodist?
3. Doctor, in my book youse doctors are still foot specialists.
4. Doctor, do you practice chiropody?
5. Doctor, what is the difference among the terms chiropodists, chiropractor and podiatrist, pediatrician?

College years are the only vacation a boy gets between his mother and his wife.

"Fust thing you gotta do, Miss Baylor, is get out of them silly high heel shoes!"

DR. POD By Bob Hughes

"No, you don't have to start treatment for that fungus right now Stanley, we can wait until it reaches your mouth and send you to a dentist!"

The man with a new idea is a crank until the idea succeeds.

"Our standard of living has risen to undreamed of levels. In the 1930's you bought an apple to help the unemployed. Now you've got to buy an auto."

Changing Times

Ole Man River Says,

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"Thinking is the hardest work there is, which is the probable reason why so few engage in it."

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Application forms, rules and regulations can be obtained from the Secretary. The final date on which papers will be accepted is May 1, 1961.

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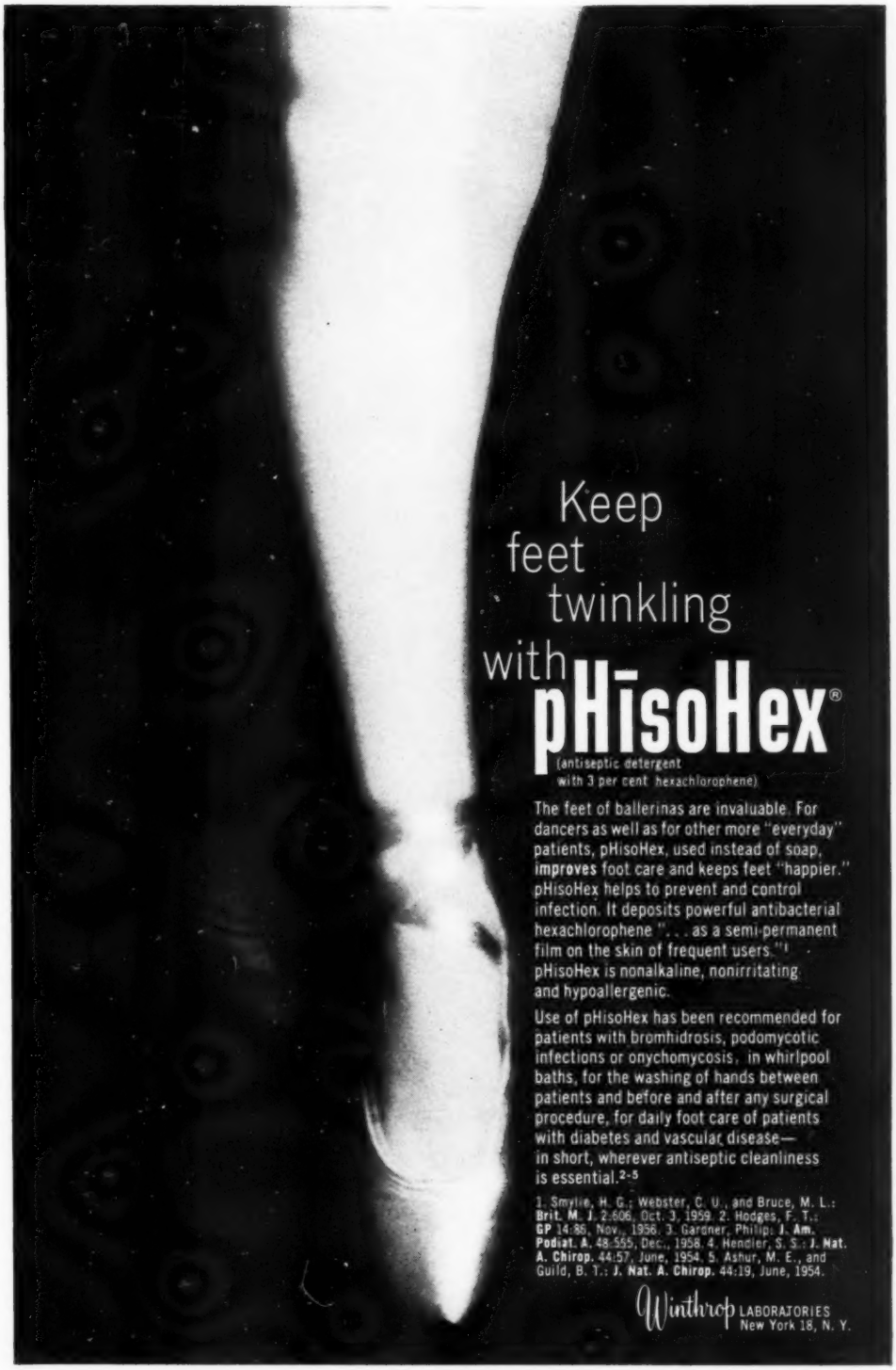
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The feet of ballerinas are invaluable. For dancers as well as for other more "everyday" patients, pHisoHex, used instead of soap, **improves** foot care and keeps feet "happier." pHisoHex helps to prevent and control infection. It deposits powerful antibacterial hexachlorophene "... as a semi-permanent film on the skin of frequent users."[1] pHisoHex is nonalkaline, nonirritating and hypoallergenic.
Use of pHisoHex has been recommended for patients with bromhidrosis, podomycotic infections or onychomycosis, in whirlpool baths, for the washing of hands between patients and before and after any surgical procedure, for daily foot care of patients with diabetes and vascular disease—in short, wherever antiseptic cleanliness is essential.[2-5]
1. Smylie, H. G.; Webster, C. U., and Bruce, M. L.: **Brit. M. J.** 2:606, Oct. 3, 1959. 2. Hodges, F. T.: **GP** 14:88, Nov., 1956. 3. Gardner, Philip: **J. Am. Podiat. A.** 48:555, Dec., 1958. 4. Hendler, S. S.: **J. Nat. A. Chirop.** 44:57, June, 1954. 5. Ashur, M. E., and Guild, B. T.: **J. Nat. A. Chirop.** 44:19, June, 1954.
Winthrop LABORATORIES
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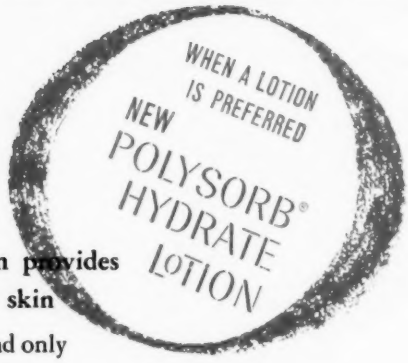
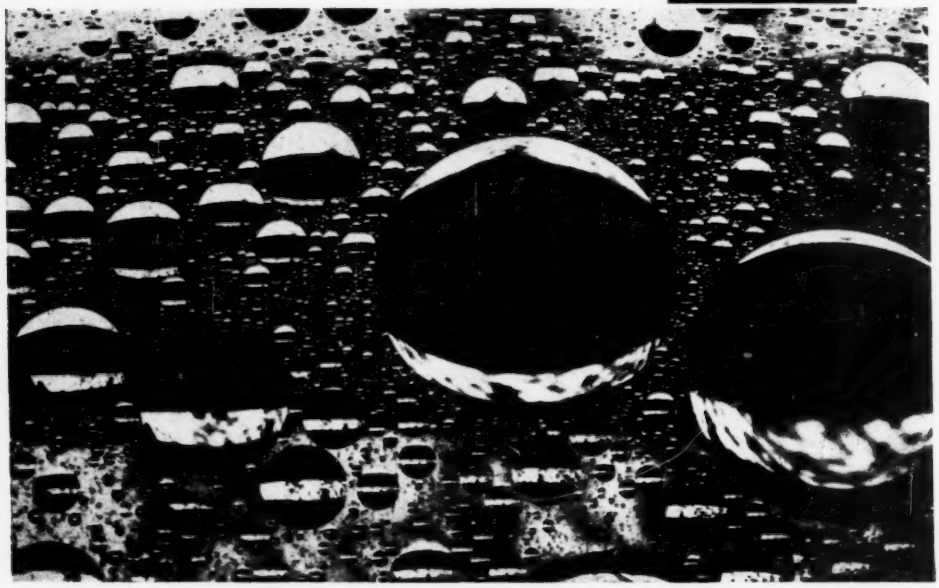
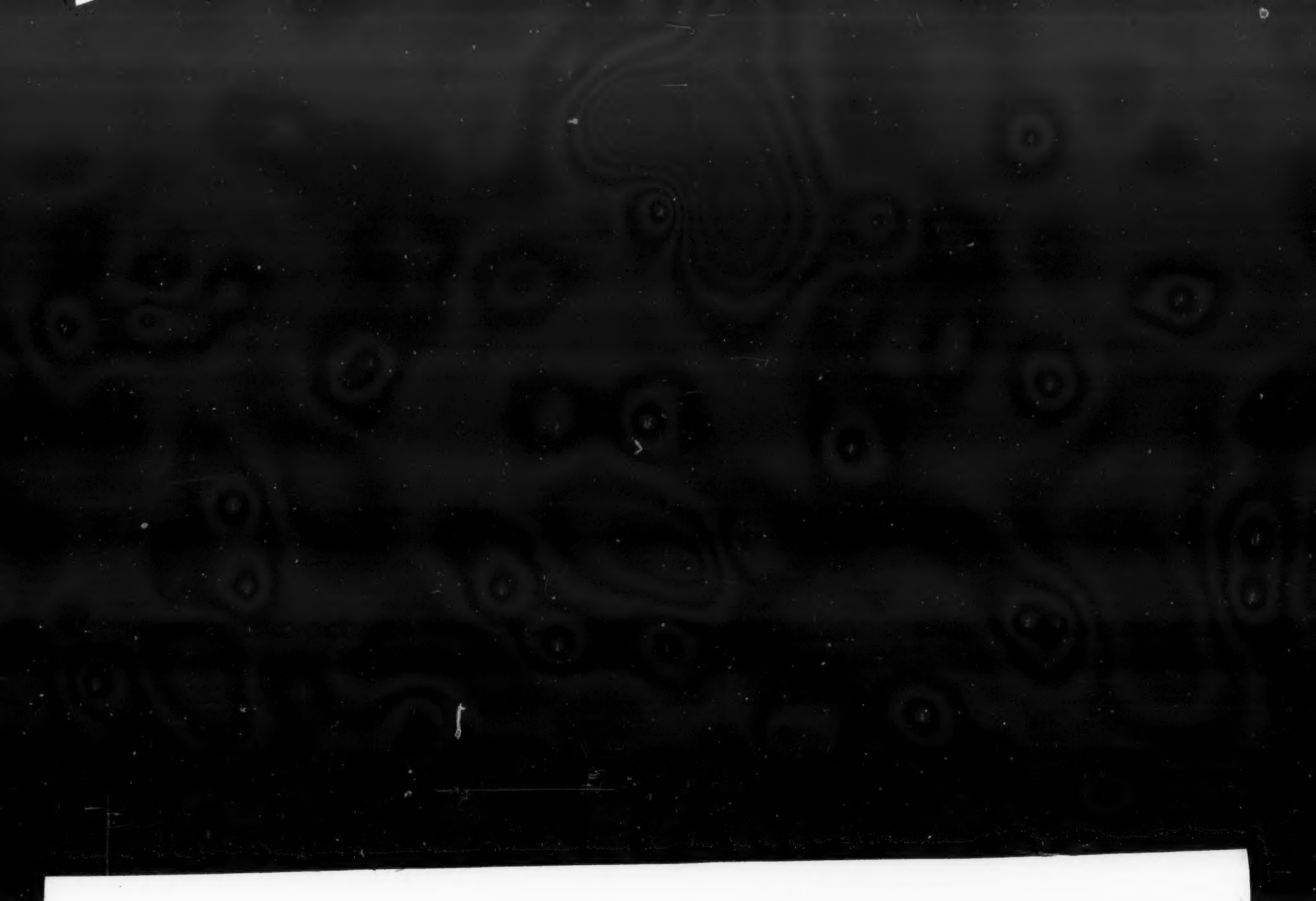
POLYSORB® HYDRATE

a balanced water-in-oil emulsion



Only a water-in-oil emulsion provides the optimum protection against dry skin . . . **Water** is the answer to dry skin, and only POLYSORB HYDRATE offers a continuous release of water for tissue rehydration. POLYSORB HYDRATE also provides prolonged emollient and protective action for the deeper cells. It is bland, non-sensitizing, non-irritating . . . your answer to dry skin and other disorders of the skin of the foot to which it may lead.

Available 50 gr. tube and 425 gr. jar. Samples on request.

E. Fougera & Company, Inc., Hicksville, Long Island, N. Y.

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